DOCUMENT RESUME

ED 375 948 PS 022 702

TITLE	Hearing on the Impact of Health Care Reform on Schools. Hearing before the Subcommittee on Select Education and Civil Rights of the Committee on Education and Labor. House of Representatives, One Hundred Third Congress, Second Session.
INSTITUTION	Congress of the U.S., Washington, D.C. House Committee on Education and Labor.
REPORT NO	ISBN-0-16-044570-1
PUB DATE	26 Jan 94
NOTE	152p.; Serial No. 103-61. Document contains several pages of small print.
AVAILABLE FROM	U.S. Government Printing Office, Superintendent of Documents, Congressional Sales Office, Washington, DC 20402.
PUB TYPE	Legal/Legislative/Regulatory Materials (090)
EDRS PRICE	MF01/PC07 Plus Postage.
DESCRIPTORS	Administrators; Advocacy; Agencies; Educational Attitudes; Elementary Secondary Education; *Federal Legislation; Federal Programs; Health Care Costs; *Health Needs; Hearings; Program Development; *School Health Services; *School Role
IDENTIFIERS	Clinton Administration; Congress 103rd; *Health Care Reform; Health Policy

ABSTRACT

These hearing transcripts present testimony concerning the impact of proposed health care reforms on American elementary and secondary schools. The hearing focused on how the proposed Health Security Act would affect and benefit schools and how American schools can assist in realizing the objectives of the Act. Much of the testimony was presented by Clinton Administration officials and representatives of education and health organizations who support the act. Testimony was heard from: (1) U.S. Surgeon General M. Joycelyn Elders; (2) Thomas W. Payzant, assistant secretary for elementary and secondary education, U.S. Department of Education; (3) the head of the New York's United Federation of Teachers union; (4) the secretary/treasurer of the National Education Association; (5) the vice president of the National School Boards Association; (6) an associate school district superintendent; (7) the director of the Vermont Department of Maternal and Child Health; (8) the executive director of the National School Health Education Coalition; (9) the executive director of the National Association of State Boards of Education; (10) the American Heart Association; (11) the American Association of University Women; (12) a professor from George Washington University; and (13) a doctor. (MDM)

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HEARING ON THE IMPACT OF HEALTH CARE REFORM ON SCHOOLS

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HEARING

BEFORE THE

SUBCOMMITTEE ON SELECT EDUCATION
AND CIVIL RIGHTS

OF THE

COMMITTEE ON EDUCATION AND LABOR
HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRD CONGRESS

SECOND SESSION

HEARING HELD IN WASHINGTON, DC, JANUARY 26, 1994

Serial No. 103–61

Printed for the use of the Committee on Education and Labor

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PS 022702

U.S. GOVERNMENT PRINTING OFFICE
80–219 CC WASHINGTON : 1994

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-044570-1

2

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CONTENTS

Page

Hearing held in Washington, DC, January 26, 1994 1

Statement of:

Duncan, Paula, MD, Director, Vermont Department of Maternal and Child Health, American Academy of Pediatrics, Washington, DC; Patrick Cooper, Executive Director, National School Health Education Coalition, Washington, DC; and Brenda Welburn, Executive Director, National Association of State Boards of Education, Alexandria, VA 82

Elders, M. Joycelyn, MD, Surgeon General, U.S. Public Health Service, Department of Health and Human Services, Washington, DC; and Thomas W. Payzant, Assistant Secretary for Elementary and Secondary Education, U.S. Department of Education, Washington, DC 3

Lubin, Alan, Executive Vice President, New York State United Federation of Teachers, Washington, DC; Marilyn Monahan, Secretary and Treasurer, National Education Association, Washington, DC; Roberta G. Doering, Local School Board Member, Agawam, MA, and Vice President, National School Boards Association, Alexandria, VA; and Michael Witucki, Associate Superintendent, Wayne County Regional Educational Service Agency, Wayne County, MI 38

Prepared statements, letters, supplemental materials, et cetera:

American Association of University Women, Washington, DC, prepared statement of 122

Americam Heart Association, Washington, DC, prepared statement of 113

American Heart Association, American Lung Association, and American Heart Association, Washington, DC, prepared statement of 119

Cooper, Patrick, Executive Director, National School Health Education Coalition, Washington, DC, prepared statement of 92

Doering, Roberta G., Local School Board Member, Agawam, MA, and Vice President, National School Boards Association, Alexandria, VA, prepared statement of 66

Duncan, Paula, MD, Director, Vermont Department of Maternal and Child Health, American Academy of Pediatrics, Washington, DC, prepared statement of 85

Elders, M. Joycelyn, MD, Surgeon General, U.S. Public Health Service, Department of Health and Human Services, Washington, DC, prepared statement of 6

Hamburg, Margaret A., MD, prepared statement of 147

Lear, Julia Graham, PhD, George Washington University, Washington, DC, prepared statement of 129

Lubin, Alan, Executive Vice President, New York State United Federation of Teachers, Washington, DC, prepared statement of 42

Monahan, Marilyn, Secretary and Treasurer, National Education Association, Washington, DC, prepared statement of 56

Payzant, Thomas W., Assistant Secretary for Elementary and Secondary Education, U.S. Department of Education, Washington, DC, prepared statement of 14

Welburn, Brenda, Executive Director, National Association of State Boards of Education, Alexandria, VA, prepared statement of 100

Witucki, Michael, Associate Superintendent, Wayne County Regional Educational Service Agency, Wayne County, MI, prepared statement of 76

HEARING ON THE IMPACT OF HEALTH CARE REFORM ON SCHOOLS

WEDNESDAY, JANUARY 26, 1994

House of Representatives,
Subcommittee on Select Education and
Civil Rights,
Committee on Education and Labor,
Washington, DC.

The subcommittee met, pursuant to recess, at 10 a.m., Room 2261, Rayburn House Office Building, Hon. Major R. Owens, Chairman, presiding.

Members present: Representatives Owens, Ford (ex officio), Ballenger, Fawell, and Barrett.

Also present: Representatives Roemer, Reed, Miller, and Strickland.

Staff present: Braden Goetz, Wanser Green, Sylvia Hacaj, John McClain, Gary Karnedy, Kathy Gillespie, and Sally Lovejoy.

Chairman Owens. Please take seats if you are remaining. If you are going, please go quietly and quickly.

The topic for the hearing is the impact of health care reform on schools, and we are pleased to start today with two very special witnesses from the administration.

The drive for educational excellence in America and the campaign for national health security are inextricably linked. Attaining the national education goals of assuring that every child will arrive at school ready to learn and that, once there, will be provided a safe and healthy environment demands more than educational reform. With nine million children in this country without health insurance and many more unable to access affordable preventive and primary care, reaching those ambitious goals requires fundamental national health reform.

Similarly, the key objectives of national health reform, including universal coverage, cost control, and placing greater emphasis on prevention, cannot be attained without the full participation and involvement of American schools.

The focus of today's hearing is this essential connection between educational and health reform. We hope to learn from our witnesses about both how the Health Security Act will affect and benefit schools and how American schools can assist in realizing the objectives of the Health Security Act.

To begin, I am pleased to welcome the Surgeon General of the United States who needs no introduction, Dr. Joycelyn Elders, the Surgeon General, Department of Health and Human Services.

Welcome, Dr. Elders.

Dr. ELDERS. Thank you.

Mr. BALLENGER. I have an opening statement, Mr. Chairman.

Chairman OWENS. I am sorry.

Excuse me, Dr. Elders.

Are there any opening statement statements?

Mr. BALLENGER. If I may, Mr. Chairman.

Chairman OWENS. My apologies, sir.

Mr. BALLENGER. No problem at all.

Today's hearing is the first hearing that this subcommittee has held on health care reform and its impact on our Nation's schools, and let me just say I am not a fan of the government-run regulatory health plan dreamed up by the President and Mrs. Clinton, but given that this may be the only opportunity this committee has to address this very important issue, I am interested in hearing how schools will be affected by the Clinton health care plan proposal.

I would also like to welcome our witnesses here today, and I am particularly concerned about the majority of grants awarded under the school-based section and how they are awarded by the Secretary of Health and Human Resources with no prominent role for the Secretary of Education.

It seems to me that if the school is to become a common, centrally located place for parents and children to access health services, the Secretary of Education should play a more prominent role, and I would hope that this could be a change that we would all agree to.

I am also concerned about how the activities outlined in the administration's health care bill will coordinate with other education program proposals that coordinate services in the school.

For example, the administration's bill authorizes $50 million for comprehensive school health education programs targeted at children and kindergarten through high school. How does this proposal affect the Elementary and Secondary Education Act reauthorization proposal and the Goals 2000 legislation regarding coordination of services? Will parents and families be able to use the school as a central, convenient location to access services? It seems that the Clinton health care proposal would duplicate that process.

Finally, I am interested in hearing from our witnesses on how much these school-related services will cost, what is included in such services, and who will pay for these services, and will reproductive health services such as birth control and abortion referral be covered, and how do school-related health services differ from the basic benefit package authorized by the Clinton Administration in H.R. 3600.

It is my hope that the witnesses today can address many of my questions, and I look forward to hearing their answers today.

Mr. Chairman, I will have to leave this hearing very shortly, so I would ask that our witnesses answer my questions for the record should I be absent when the question section comes.

Thank you, Mr. Chairman.

Chairman OWENS. Thank you.

Any further opening statements?

Mr. BARRETT. I too welcome the witnesses, Mr. Chairman. No opening statement in the interests of time. I may have some questions later.

Thank you.

Chairman OWENS. Thank you.

Mr. Fawell?

Mr. FAWELL. I have no opening statements. I welcome the witnesses and look forward to their comments. I am interested in how this coincides with the fact that every child will be covered by a regional alliance and have his accountable health partnership plan available and so forth. So I look forward to the testimony.

Chairman OWENS. Dr. Elders, you may begin.

STATEMENTS OF M. JOYCELYN ELDERS, MD, SURGEON GENERAL, U.S. PUBLIC HEALTH SERVICE, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC; AND THOMAS W. PAYZANT, ASSISTANT SECRETARY FOR ELEMENTARY AND SECONDARY EDUCATION, U.S. DEPARTMENT OF EDUCATION, WASHINGTON, DC

Dr. ELDERS. Thank you, Chairman Owens, Mr. Ballenger, and other members of the subcommittee.

I am delighted to be with you today to talk about the impact of health care reform on schools. I appreciate the leadership you and your subcommittee have shown in providing all of us the opportunity to be here today to discuss this important aspect of the Health Security Act. My presence here today with Dr. Payzant demonstrates the collaborative effort between the Department of Education and the Department of Human Services in providing and working with these programs.

In the last five years, numerous reports have detailed the growing and complex problems our youth face—suicide, homicide, HIV/AIDS, teen pregnancy, violence, drug and alcohol abuse, to name a few. Each year, more than 5,000 teens end their lives and another 4,000 attempt suicide. Homicide is the leading cause of death for young men ages 10 to 24. AIDS is increasing most rapidly in our adolescents; one in 77 school-age children in Washington, DC are HIV positive. More than three million adolescents contract a sexually-transmitted disease each year. One-third of high school seniors report binge drinking, and 40 percent report having tried an illicit drug. Each year, more than 500,000 babies are born to teenagers, putting them at risk for school failure, poverty, and welfare dependency.

What is most distressing is that 70 percent of the cause of adolescent illness and death is preventable, preventable by education, preventable by early identification of risk factors, preventable by access to appropriate health services. Congressman Owens, if we are to improve the health of America, we must focus on prevention, a key strategy in the President's Health Security Act.

Health behaviors established during childhood and the teenage years contribute to many of the poor health, educational, and social outcomes of adults. We must educate our population on how to improve their own health.

The proposal starts with a comprehensive health education program for all children from kindergarten through 12th grade. The second part of the plan that will improve health, especially in our adolescents, is a commitment to access. Adolescents make up the most medically underserved age group in America. Only 70 percent of adolescents have health insurance, and this coverage often excludes the preventable and psycho-social services that are so important to improving adolescent health.

But adequacy of financial coverage, sir, is just one barrier to health care for teens. Multiple nonfinancial barriers also exist. Teenagers often fail to keep appointments, do not know where to find services, and are concerned about obtaining confidentiality. The few health services they may access are focused on physical ailments and fail to identify the psycho-social, behavioral, and mental health needs, the most common needs of adolescents.

Schools can become the equalizing factor in our society. Children have no choice of their parents, their socioeconomic status, their heritage, their race, or their religion, but the school environment is a place where everyone could stand on an equal footing.

In order for schools to accomplish this goal of educating children, they must first address some of their other needs. These needs too often make our children members of what are called the 5–H Club: Children that are helpless, children that are homeless, children that are hungry, children that are hopeless, children that are hugless.

Schools can help break down barriers and link young people to necessary services. As such, schools have a wealth of potential for ensuring the future health and well-being of our young people as more than 95 percent are in school every day. Therefore, I believe that our greatest chance of improving the health status of our young people lies in early, ongoing preventive services to their health development which is best accomplished through a combination of comprehensive health education and access to health services. I believe that school-linked health services are an important innovation in health care for many of our youth.

The administration recognizes the importance of these two approaches to promote preventive health measures and to assure access to services. Therefore, the Health Security Act includes two new Federal programs that would support efforts to design and implement comprehensive school health education and school-related health services.

Only 52 percent of the ninth graders, 12 percent of 10th graders, and 2 percent of 11th and 12th graders currently receive any instruction in health education. Our children spend 12,000 hours in school from K through 12 in reading, writing, and arithmetic, only 43.4 hours in health education. Compounding the problem of inadequate numbers of health education programs, we find that these programs are often fragmented, targeted, and not comprehensive.

Fifty million dollars of the Health Security Act will be used to support planning and implementation grants to State education agencies and large local education agencies for comprehensive school health education for children K–12.

The Health Security Act authorizes $100 million beginning in fiscal year 1996 to support planning and implementation grants to States and local communities for school-related health services focusing on our adolescents in the most deprived schools.

The Health Security Act targets funding to those communities of greatest need. It is estimated that there are currently 5.4 million students in over 9,000 middle and high schools with a prevalence of poverty and other risk factors. Poverty is greater than 30 percent in these schools. These young people frequently engage in high-risk behaviors and are most likely to experience the multiple nonfinancial barriers I discussed earlier.

This initiative will improve access to health and psycho-social services to up to 3.2 million of these youth and over 35,000 schools, with priority given to schools with the highest percent of youth in need.

I know that comprehensive school health education and school health services are a priority for this administration because I spent a great deal of my time before I came here educating your President on their importance. He now tells me when I talk about this that I am preaching to the choir.

As I travel our country, I have sensed a new receptiveness to both of these programs. The programs are cost-effective, they make good sense, they will bring our schools the kind of education and health habits that our young people need to survive. I believe they will also lead to a partnership with States and local communities that will provide programs that will improve the health of our schoolage youth and help them to grow up healthy, educated, motivated, and with hope for the future. As your Surgeon General, I know of no worthier cause.

Thank you.

[The prepared statement of Dr. Elders follows:]

M. JOYCELYN ELDERS, M.D.

Chairman Owens, Mr. Ballenger and members of the Subcommittee. I am delighted to be with you today to talk about the impact of health care reform on schools.

Today, I will be focusing my remarks on an issue near and dear to me -- improving the health of our youth through one of the best means possible -- comprehensive school health education and school related health services: two essential components of the President's Health Security Act.

The Role of Schools Under Health Care Reform

Schools can provide a superb opportunity to reach our bright young people in a way that can be what I refer to as an "equalizing factor." Schools can be a great equalizer by teaching all young people early how to protect their health and how to use health and social services effectively. Schools can also help to break down barriers and link young people with necessary services. As such, schools have a wealth of potential for ensuring the future health and well-being of young people.

The Health Security Act holds great promise of reducing costs by minimizing the risks of serious illness, costly inpatient care and inappropriate use of hospital emergency rooms.[1] Schools are a highly efficient way in which to reach many young people in the United States with comprehensive health services. With a majority of school-enrolled youngsters, school-based and school-linked clinics offer a unique opportunity to provide comprehensive health services to youth and to realize potential future cost savings.[2,3]

The President's proposal for health care reform recognizes the specific health needs of children and adolescents, and the role that schools can play. Schools provide an unique opportunity because they not only offer a "natural" setting where youth assemble on a regular basis, but also because education and health promotion can be integrated into the learning environment with school-affiliated activities. I believe that our greatest chance of improving the health status of our young people lies in early and ongoing protection of their health and development -- which is best accomplished through a combination of comprehensive health education and access to health services.

Comprehensive health education should be taught to all children, starting in kindergarten and continuing through high school. A sequential, age and developmentally appropriate approach to school health education would provide every child with a foundation of knowledge for risk reducing and health promoting behaviors. Ideally, a comprehensive health education program would provide information on many related health topics, including -- growth and development, nutrition, safety, first aid, injury and violence prevention, environmental health, tobacco and other substance abuse, disease prevention and control, mental and emotional health, family life, and human sexuality.

As I am sure you know, I have also long been in favor of school-based and school-linked health programs in order to provide health services to young people who would otherwise not have access to such services. Such school-related health services are logical partners of comprehensive school health education in that they can increase access to primary and preventive health care. And, there is a great need for improving the delivery of health services to school-aged youth. Despite the physical and

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emotional stresses school-age youth face, they rarely get the preventive care, counseling, health education, or social supports they need. And, while providing all individuals with access to health care services is the cornerstone of meaningful reform, health insurance coverage alone will not address the non-financial barriers that many school-aged youth, particularly adolescents, face in utilizing services.

The Administration's health care reform proposal recognizes the importance of these two approaches; comprehensive health education and school-related health services to promote preventive health measures and to ensure access to services. These two new Federal programs are designed to support and implement comprehensive school education programs and school-related health services. The comprehensive school health education proposal would authorize $50 million annually beginning in fiscal year 1995 for grants to States and local communities to support comprehensive health education programs in grades K-12. The school-related services proposal would authorize $100 million in fiscal year 1996 (growing to $400 million by the year 2000) in grant funding to States and local communities to provide a range of health and other enabling services to school-aged youth, primarily targeted to poor, high-risk youth aged 10-19.

Barriers to Health Care

The delivery of coordinated health and social services to school-aged youth, particularly adolescents, must be designed to overcome more than just financial barriers. The Health Security Act makes efforts to ensure that both financial and non-financial barriers are addressed for underserved populations. Some non-financial barriers which often affect adolescents include:

(a) inconvenient appointment hours;

(b) distrust or lack of knowledge about existing health care providers that are typically geared toward the problems of younger children or adult-oriented;

(c) concerns about confidentiality of care;

(d) lack of transportation to health care providers;

(e) general apprehension about discussing health problems and/or denial that a problem exists; and

(f) cultural or ethnic barriers.

According to the Congressional Office of Technology Assessment (OTA), adolescents make up the most medically underserved age group in the United States, with a heavy burden of preventable morbidity and mortality and yet, adolescents seek care less often than any other age group. The care received is often provided by sub-specialists who may lack a comprehensive or preventive approach. Opportunities for critical preventive intervention are missed. Under the Health Security Act, new opportunities for intervention will be available to improve access to health care for school-aged youth and adolescents and to improve their long term health and general well-being.

I believe that school-linked health services are an important innovation in health care for school-aged youth and that integrated, prevention-oriented approaches can help reduce many access barriers. A decade ago, school-based health centers were a rarity. Since 1985, however, their numbers have grown dramatically to over 500 that currently exist across the country.

As you know, I worked very hard during my time in Arkansas, selling school based clinics to anyone who would listen. The start-up of such programs is slow because you must involve the entire community in the process of seeking a school-based clinic and determining what services should be provided by that clinic. And, most importantly, you must give parents the chance to decide if they want their child to use the clinic, and if they do, what services they may not want their children to receive in the clinic. But, we found that once a school actually went through the process of applying for a clinic and got their clinic on site, they could see the important needs the clinic fulfilled for their students. Soon all the other schools in that area wanted a health clinic. And, if you tried to take that clinic out, you really had a battle on your hands.

We learned for such clinics to be successful, there must be local ownership. Providing funding for school-related health services, without providing for the nurturance to get the community involved in the planning and development of the clinic will be a waste of our money.

School-Related Health Services

The President's proposal authorizes $100 million beginning in fiscal year 1996 to support planning and implementation grants to States and local community partnerships for school-related health services focused on adolescents aged 10-19. Building on school-based and school-linked demonstrations that have shown promise, the plan targets areas with the highest need as demonstrated through high rates of poverty, adolescent pregnancy, sexually transmitted diseases, HIV infection, substance abuse, community or gang violence, and unemployment.

Based on local needs assessments, programs will be designed to provide young people with preventive health services; mental health service and social services counseling; substance abuse counseling, care coordination and outreach; management of simple illnesses and injuries; and referral and follow-up for more serious conditions. In order to promote the use of health services available through these school-related health programs, no cost-sharing will be required of participants.

The proposal targets funding to those schools or communities with the greatest need. It is estimated that there are currently 5.4 million students age 10-19 in 9,411 middle and high schools with a high prevalence of poverty and other risk factors. These young people, who frequently engage in high risk behaviors, experience multiple non-financial barriers to health care. This initiative will improve access to health and psycho-social services for up to 3.2 million school-aged youth in over 3,500 schools, with priority given to schools with the highest percentage of youth in need. As a result of targeting services in high-need areas, we expect to see a reduction in the preventable morbidity and mortality that school-age youth, especially adolescents, experience. Grants to State and local consortia will support the provision of services at sites throughout the country in areas of greatest need.

School-related health providers funded under this proposal will be certified automatically as "essential community providers" (ECP's), a program that provides transitional protection to federally-funded programs and other programs delivering care in underserved areas. The ECP provisions require health plans to enter into a participation agreements or payment agreements with all ECP's. Under a participation agreement, health plans will be required to treat the ECP in terms and conditions at least as favorable as other providers participating in the plan. School health providers are an exception to these rules, in that the Secretary will determine an appropriate payment methodology in the future. This is an effort to help simplify the administrative work so that each school-based health center will not have to create individual links with multiple health plans in their areas.

School Health Education

The essence of prevention in health care is education. This means educating all Americans, beginning with our children, about how to maintain their own health and avoid behaviors that we know lead to tragically high rates of disability and premature death. Yet, only about half of the 9th graders, and less than 5% of high school juniors and seniors receive any health education at school. For children and adolescents the leading health problems are from causes that are largely preventable: injuries, both violent and unintentional; unintended pregnancies; STD's, including HIV/AIDS; substance use, including tobacco and alcohol; and, unidentified or untreated emotional and psychological problems which are often the underlying causes of other problems. Furthermore, the behaviors and attitudes that are developed during childhood, the most formative years of our lives, greatly influence the occurrence of diseases later in life. Behaviors established during childhood and adolescence, such as tobacco use, unhealthy eating habits, and inadequate physical activity contribute to the major health problems seen in adults several decades later: heart disease, stroke, high blood pressure, and cancer.

The President's Health Security Act includes a relatively small, yet extremely important initiative to begin providing school-aged children, grades K to 12, the comprehensive health education necessary to remain healthy and to perform at their maximum potential as students and eventually as members of the work force. Under the Administration's proposal, $50 million is authorized each year to support the planning and implementation of comprehensive school health education programs. This money will be made available to State education agencies as well as some of the nation's largest local school districts. The money will be targeted to those schools with a disproportionate number of children at risk for poor health outcomes and in particular need of health education services. The programs will be designed by State and local authorities to address those health issues that are most pressing in their own communities. There will be no federally mandated curriculum, but programs will be expected to address all of the basic components of a comprehensive health education curriculum. We have worked very closely with our colleagues from the Department of Education, including Dr. Payzant, in developing this initiative and feel that it is the right kind of program at the right time to begin making a difference in the health of our children.

While the amount of money is not large, only $50 million, the potential benefits are significant. This initiative allows for integration of existing, federally funded, categorical health education programs with the new comprehensive program through a newly created waiver authority. This will ensure that not only the new money is used wisely and efficiently, but that current funding sources are used more productively as part of a comprehensive program. We believe the state and local education agencies are wanting to do this and that is why we included it in the President's program.

As a matter of public health policy, comprehensive school health education and school-related health services are a priority. With sufficient support, such programs can bring into schools the

kinds of education and preventive health habits, as well as comprehensive health, mental health, and social services that so many young people need to "make it." With Federal program funding and continued education efforts, I believe many communities will be receptive to supporting such programs as promising approaches to improving the health of America's school-aged youth.

1. Brindis, Claire, "Health Policy Reform and Comprehensive School Health Education: The Need for an Effective Partnership" Journal of School Health. January, 1993, vol. 63, no. 1

2. In 1989, 95.7 percent of all 14-17 year olds were enrolled in school (public, private and parochial). "Youth Indicators: Trends in the Well-being of American Youth" 1991.

3. "Teenage Pregnancy and Too-Early Childbearing: Public Costs, Personal Consequences 6th Edition, 1992; Cost to the Federal Government and Selected States and Cities, The Center for Population Options.

Most recent information (FY 1990) on the Federal costs (AFDC, Food Stamps and Medicaid) for teenage childbearing estimates that the single year public cost or all families started by a teenage birth was over $25 billion, up an alarming 16 percent, or $3.5 billion, form 1989. Estimates are that if every birth to a teen mother have been delayed until the mother was in her 20s, the U.S. federal government would have saved 40 percent of the calculated expenditures, or $10.02 billion. Considered a different way, the average public cost for each family started by a teen birth is estimated to be $54,399 over 20 years.

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Chairman OWENS. Thank you.

Dr. Payzant.

Dr. PAYZANT. Thank you, Mr. Chairman and members of the committee. I am pleased to be here with Dr. Elders to speak about the importance of health in education and our expectations for the positive impact of the Health Security Act on schools and the young people in them.

There is a strong commitment by the Departments of Education and Health and Human Services to work together to make sure that the Nation's children are healthy and educated and ready to face the challenges that await them. We have worked together to develop the programs proposed in the Health Security Act that will most directly affect the schools. Our partnership is developing in other areas as well. Secretaries Shalala and Riley have issued a joint statement on school health. Dr. Phil Lee, who is the Assistant Secretary for Health, and I cochair the Interagency Committee on School Health.

I am making my comments today wearing several hats, obviously as Assistant Secretary for Elementary and Secondary Education, as a former school teacher, and a long-time school superintendent in small, medium-sized, and large districts, and, I expect most importantly, as a parent and grandparent. These perspectives and my experience help me make these comments with, I think, a sense of commitment and understanding that I hope will be persuasive.

I have several major points. The first major point is that, as we probably all know but sometimes don't acknowledge, health affects education. Education contributes to improving the health of children and health status. It is a major determinant of educational achievement. If you look at the first national educational goal, every child coming to school ready to learn, there is the connection between the health of that child and that readiness to learn. The sixth national education goal, that all schools will be safe, disciplined, and drug free, also acknowledges a connection between health and education. Both of these goals relate to health and education both.

Again, my teaching career, which began 31 years ago—in those days infectious diseases such as measles, polio, whooping cough, and scarlet fever were the major health threats to young people. Certainly immunizations have helped dramatically reduce the threat of these diseases, although we are still challenged to make sure that all children are immunized.

Today the health threats to children are a little bit different. Certainly immunizations are still important, but health threats are found in the social environment and often the result of the behavior of our young people.

The vast majority of things that affect a young person's health—accidents, substance abuse, sexual activity leading to unwanted pregnancies, and sexually transmitted diseases, suicide, violence, heart disease, and cancer caused by smoking or poor nutrition—all of them are preventable, and that is an important message.

I think we all know that schools are the places where most children and youth spend a significant amount of time, and schools need to play a larger role, with proper support, of course, in addressing the health and behavioral problems that often limit academic achievement, good public health, and economic productivity.

My second major point is related to the impact of the Health Security Act on schools. There are three specific components that I want to mention that would assist schools in helping children and youth to enter the classroom ready to learn, to develop the knowledge and skills that they need to avoid health risks, and maintain good health throughout life.

The first component focuses on prevention. Schools have historically played an important role. In fact, 95 percent of schools now require immunization prior to admission, and many schools screen children for vision, hearing, and other health problems. The Act's health benefits package would provide every child access to health screenings, immunization, prescription drugs, eyeglasses, dental care, rehabilitative services, and, when fully phased in, mental health and substance abuse services would be available. That is, a child who is unable to concentrate on his or her studies because of a health-related problem would receive care.

The second component is the comprehensive health education proposal and school-related health services program that Dr. Elders talked about in her testimony. These programs would provide the grants to States and communities under broad Federal guidelines while ensuring the flexibility—and this is important—for those communities to develop their own programs to meet local health needs. Both programs would concentrate on three areas to maximize the impact—positive impact—on children. First, emphasis on local community involvement and determination in designing the programs; second, collaboration between local and State health and educational professionals; they have got to work together at all levels—local communities, State and nationally—and, third, coordination with existing Federal, State, and local programs.

An example from my own experience was the New Beginnings effort in San Diego where there is an ongoing partnership between the city, the county, the school district, the community college, the University of California, San Diego Medical School, Children's Hospital, and the Housing Commission to coordinate services that focus on the needs of children and youth, health being one of the major ones. From New Beginnings you learn that the community has to figure out what its commitment will be and how the various players will work together to the end of improving the health and education of all young people.

The third component, other health-related initiatives in Goals 2000, Educate America Act, would codify the national goals and objectives. As I mentioned, goals one and six relate directly to what we are talking about today.

In our proposed reauthorization of the Elementary and Secondary Education Act, I would like to cite two things. Nearly one out of four children from households with annual incomes of $25,000 or less are not covered by a health insurance plan or Medicaid, and in 1987 nearly a third of the uninsured children did not have a preventative care visit during the previous year.

In the administration's proposal, we are suggesting that in all elementary schools that have a 50 percent poverty level or above, health screenings would be provided to children twice in the child's elementary school career, with the costs of those screenings covered by other sources and Title I dollars used as the last resort dollar for this purpose. Of course, if the Health Security Act passes and has universal coverage, as the President firmly believes it should, then that would cover the cost of those screenings and Title I moneys would not be needed for this purpose.

I want to mention in ESEA reauthorization, school districts and schools would begin in their plans to talk about coordinated services and how they are approaching work with other agencies in the community and could use Title I dollars not for the services themselves but for the collaborative efforts that are so necessary to get things going. As this subcommittee knows just from their action a half hour ago, the safe and drug-free schools component of the bill would provide a comprehensive, integrated approach to drug abuse and violence prevention by recognizing the relationship between drug abuse and violent behavior.

I think you can see that there is a direct connection between health and education; and that the Health Security Act components are very important here. They would connect to other legislation that the administration has that focuses on education.

Thank you for the opportunity to speak. I would be happy to answer any questions that you may have.

[The prepared statement of Mr. Payzant follows:]

STATEMENT OF THOMAS W. PAYZANT

Mr. Chairman and members of the Subcommittee, I am pleased to be here with Dr. Joycelyn Elders to speak about our expectations for the impact of the Health Security Act on schools.

Dr. Elders' and my presence here is a visible and important sign of the cooperation and commitment our two departments share in seeing to it that the Nation's children are healthy, educated, and ready to face the challenges ahead of them.

Over the last year our two departments have worked collaboratively to develop the programs proposed in the Health Security Act that will most directly affect the schools. This partnership continues to grow. Efforts such as the joint statement on school health, signed by Secretary Riley and Secretary Shalala, and the Interagency Committee on School Health, which I co-chair with Dr. Phil Lee, Assistant Secretary for Health at HHS, confirm that health care and education are close and inseparable partners helping young people become self-sufficient, productive members of society.

I speak on this issue of school health not only as an Administration official but also from the vantage point of a former teacher, past superintendent of schools, and current parent and grandparent. These perspectives help me to understand the critical importance of working to ensure that children have access to comprehensive health education and services to enable them to choose and lead healthy lives.

II. Health affects learning.

Education contributes to improving the health of a child, and a child's health status is a major determinant of educational

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achievement. The relationship is so intrinsic that the first National Education Goal is that, by the year 2000, all children will start school ready to learn. An objective central to achieving that goal is that children will receive the nutrition and health care needed to arrive at school with healthy minds and bodies. The sixth national education goal is that all schools will be safe, disciplined, and drug-free. Every school district will develop a comprehensive K-12 drug and alcohol prevention education program as an integral part of health education.

Both goals directly relate to health. To be ready to learn, children must be able to see the blackboard, hear the teacher, not be impaired by drugs and be healthy enough to concentrate on what is being taught.

I began my teaching career 31 years ago. At that time some of the most pressing health problems facing children in our schools included infectious diseases such as measles, polio, whooping cough, and scarlet fever. The availability of, and the requirement to obtain immunizations, for children have decreased those threats though we are still challenged to see that children receive proper immunizations at the appropriate age.

It is a different world today. Immunizations are still important as evidenced by the increase in measles cases in the late 1980's and by the increase in whopping cough cases recently. In addition, significant threats to children's health are found in their social environment and are often the result of their own behavior. Unlike my days as a teacher, the health needs of today's children have become increasingly complex. Of the health threats to children today, the vast majority -- including substance abuse, sexual activity leading to unwanted pregnancies and sexually transmitted diseases, suicide, violence, accidents, heart disease, and cancer caused by smoking or poor nutrition -- are preventable.

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Nearly 43 million children attend elementary, middle, and high schools each day in the United States. Schools are on the front line and have a major influence on the child's development and intellectual and social growth. As community institutions, schools must play a larger role in addressing the health and behavioral problems that limit not only academic achievement, but also our Nation's public health and economic productivity.

III. The Impact of the Health Security Act on Schools

The Health Security Act is the President's major initiative for improving the health status of all Americans. Three specific components of the Health Security Act would assist schools in helping children and youth to enter the classroom ready to learn. They also help to develop the knowledge and skills children and youth need to avoid health risks and maintain good health throughout life.

Prevention

Through the comprehensive benefits package and other proposed programs, the Act places an emphasis on prevention rather than on intervention. This is critical to enhancing the lives of individuals in both the short and the long term.

Schools have historically played a role in ensuring that students receive necessary preventive care. Ninety-five percent of schools now require immunizations prior to admission, and many schools screen children for vision, hearing, and other health problems.

The benefits package proposed in the Health Security Act would provide every child access to health screenings, immunizations, prescription drugs, eye glasses, dental care, rehabilitative

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services and, when fully implemented, mental health and substance abuse services. Implementation of the benefits package would mean that a child who is unable to concentrate on his or her school lesson because of a toothache will receive care. Or a child with an ear infection will receive medication so the problem will not deteriorate into an acute problem or even result in hearing loss.

Comprehensive Health Education and School-Related Health Services Programs

Two programs within the Health Security Act have direct impact on schools: the comprehensive school health education and the school-related health services. These programs would provide grants, under broad Federal guidelines, to communities while ensuring the flexibility for those communities to develop their own programs to meet the local health needs.

To maximize impact on children both programs include: (1) emphasis on local community involvement and determination in designing the programs, (2) collaboration between local and state health and education professionals and (3) coordination with existing federal, state and local programs.

Prior to my position at the Department, I was involved with a successful collaborative community program in San Diego called New Beginnings. This integrated service effort was developed to address social, physical, psychological, and economic needs of children, youth, and families within the community. I remain convinced that schools must play a leading role in these areas.

We learned several lessons in developing this model in a local San Diego elementary school. Key to the success of New Beginnings was that the program was developed by the community for the community, through the efforts of numerous very talented and committed school and local leaders.

Beginning in FY 1995, the Comprehensive School Health Education and the School-related Health Services proposals share that same principle. Much like the New Beginnings, these proposals recognize that each local program must be driven by community commitment from the bottom up. That does not mean to the exclusion of Federal and State involvement, but the local communities must take ownership.

In developing these two proposals with HHS, we recognized that health, social service, and education professionals must be partners in the design and implementation of the program. Much like the collaboration that is being demonstrated at the federal level by the Departments of Education and HHS, the state and local agencies must work together to a common end.

The Comprehensive School Health Education program would provide $50 million annually for planning and implementation grants to State educational agencies and large local educational agencies. The program would also allow communities to seek waivers from current Federal program requirements in order to maximize the dollars they can spend to develop a comprehensive program. This program would be a significant step in aiding communities in their efforts to develop effective programs.

IV. Other-Health Related Initiatives

Schools must be active players in health care reform. The Health Security Act is the a major step toward recognizing the critical role of schools in the area of health. However, there are two other initiatives that complement and support this proposal.

First, is the Goals 2000: Educate America Act. This is the leading edge of the Administration's strategy to reinvent the federal role in education and to provide support and leadership to the national effort to overhaul the elementary and secondary

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education system. A major component of Goals 2000 is to codify the six National Education Goals and objectives. Goals one and six directly relate to the health of children and the role of schools in assisting these efforts.

This legislation provides a framework for other education reform proposals, including the "Improving America's Schools Act", the Administration's proposal for reauthorization of the Elementary and Secondary Education Act.

In developing the ESEA legislation there was a recognition that schools have an important role in linking students to health care to help ensure that all of America's children are ready to learn. To do so, we must provide a means to identify children's health needs. Health screenings are fundamental to this effort.

Nearly one out of four children from households earning less than $25,000 per year is not covered by a health insurance plan or Medicaid. In 1987 almost a third of uninsured children did not have a preventive health care visit during the previous year.

The ESEA proposal includes a provision to require that school districts establish a procedure to ensure that all students in Title I elementary schools enrolling 50 percent or more low-income students receive, at a minimum, two health screenings during the elementary school years, at appropriate intervals based on reasonable pediatric standards. Schools would not be required to provide screenings themselves and Title I funds could be used to pay for screenings only where other funds are not reasonably available.

Health screenings would be part of the comprehensive benefits package under the Health Security Act. Once that legislation is passed, Title I funds would no longer be used to pay for

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screenings. However, schools will continue to have the important role of outreach and referral for health screenings.

Under the Administration's ESEA reauthorization proposal, school districts would also include in their Title I plans, a description of how they plan to coordinate and to the extent feasible, integrate Title I services with community health, social, and educational services in order to maximize effectiveness in delivery of available services to students and their families. This would allow schools to better coordinate with local and State health and social services.

Through Title IV -- Safe and Drug-Free Schools and Communities, ESEA also takes a comprehensive, integrated approach to drug and violence prevention by recognizing the relationships between drug use and violent behavior. The Administration's proposal builds on the success of schools working with larger communities in creating drug-and violence-free environments both within and outside schools.

Thank you for the opportunity to speak with you about the Health Security Act and the reauthorization of ESEA as they would affect schools. I know you will be hearing from other members of the education community later this morning. We are interested in working with you and them to develop the best programs to help our children.

Chairman OWENS. Thank you.

The Chair would like to welcome two members of the full committee—Congressman Roemer from Indiana and Congressman Miller from California.

I would like to yield at this point to Mr. Ballenger since his pressing schedule meanings he will have to leave soon.

Mr. Ballenger.

Mr. BALLENGER. It is interesting; the pressing schedule I have got is a gathering of Friends of Tobacco, and having heard both your discussions, I am quite sure that maybe the friends aren't quite located here at this panel.

[Laughter.]

Mr. BALLENGER. Dr. Elders, you are noted for being outspoken, and I'm a politician, and I recognize—you have got to realize, I come from the solid Baptist country of North Carolina, and not knowing exactly what services will be provided at this level, let me just straight out ask a brutal political question that is going to have some effect on where this bill runs. Will birth control and abortion referral be provided through the school-based health program?

Dr. ELDERS. Mr. Ballenger, what schools provide in their school-based health clinics will be under local control, determined by the local school board. Schools can have these clinics and provide every service with the exception of reproductive health if that is the decision that their school board makes. School boards are representative of what that community thinks. In Arkansas all 24 of our school-based clinics were voted on by the school board. Each school district chose what they wanted to have in their school-based clinic; some dispensed contraceptives, some did not.

I know of no school that would be set up to ever provide abortion services. That would not be something that I would feel school-based clinics would be in the business of providing.

Mr. BALLENGER. I think you took half the problem away. The other half, I guess we will have to face when the time comes.

Doctor, I am just curious, my wife and I founded a day care center and she still runs it. A day care center for minority—not necessarily minority only but welfare children. The bill, targeting health care to children ages 10 to 19 and seems to aim itself more at sexually oriented problems rather than the health problems that face young children and teens. You have been in kindergarten and so forth and realize that once anybody gets sick at all, the whole place gets sick.

Health services—at least as far as we were able to understand and were able to use our local county health department to come in and check it out, and the fact that we were feeding everybody was in some cases the only good meal they had all day—do you think targeting 10 to 19 is exclusive in its effort?

Dr. PAYZANT. I think the argument is very clear, Mr. Ballenger, that everyone needs good health care, health care that focuses on prevention first, and the universality of coverage is the fundamental principle of the administration's proposal.

Having said that, if you look at the data, the data are very clear and frightening. What tends to happen when children move toward adolescence is that families and parents tend to back off a little bit in terms of their concern about pushing health care. The awkwardness that some young people feel in reaching out for it or not knowing what they should have or what might be accessible increases, and there is less availability of quality services for that adolescent and teen group. This is the reason that we are suggesting that the schooling services focus on that particular age group.

Mr. BALLENGER. To be exclusive in allowing the grants to even go to anybody—Yes, Ma'am?

Dr. ELDERS. Yes, I think we say schoolage children, with a major emphasis on the 10- to 19-year age group, but, as you know, in many smaller areas, certainly in Arkansas, has from kindergarten through 12th grade in one school.

Mr. BALLENGER. Right. Some of the areas of North Carolina that I cover are exactly the same.

Dr. ELDERS. Yes.

Mr. BALLENGER. I would be curious as to the experience in Arkansas when the school districts came around and set up the programs that you had suggested. Was it ever specifically stated as part of their program that abstinence might be—I mean over and over again we are hearing of all the problems of the sexually active teenagers and so forth, but I never hear anybody in education or anywhere else preaching the idea that abstinence—I mean it really is preaching, I guess—the idea of abstinence. How did it come out in Arkansas?

Dr. ELDERS. Mr. Ballenger, yesterday I spent the day at the faith group at the Carter Center talking to the ministers. I told them I feel that we ought to start early. I feel that we have been doing too little too late, as I know you believe since your wife is running a day care center.

If you start early, you are teaching children good behavioral habits, teaching them how to say no, how to feel good about themselves, how to say that there are certain places on their bodies nobody should touch; if they do, tell somebody. You are teaching and reinforcing abstinence.

Mr. BALLENGER. Let me ask you, are teachers actually allowed to teach that? Usually teachers are scared to death to mess with something like that.

Dr. ELDERS. Well, that was one of the things that came up. But I think you teach that to your children.

Mr. BALLENGER. Right.

Dr. ELDERS. I teach that to my children. But many of the 13, 14, 15-year-old parents from very poor neighborhoods or very poor communities are not taught those same things. They do not see the kind of behavior modeled in their home that you see modeled in your home. If we are going to ever make an impact and change our society and change our children's health, we need to start early in the schools; the only institutions where all children go.

Mr. BALLENGER. But are we as a group willing to—and I feel sorry for teachers, I will be frank with you, because they are so restricted as to what they can do; they are scared to death of getting sued. If you touch a child, you are going to be either accused of sexual harassment or brutalizing, and they are going to be chosen to be teaching these particular things? It is going to be difficult, I would say.

Dr. ELDERS. I feel that we are going to have to teach our elementary school teachers how to teach health education. We need more health education teachers in our junior high, our middle schools, and our high schools to teach our bright young people. I certainly understand it will be a difficult problem.

In Arkansas we found that our parents really welcomed the opportunity of having somebody to talk to their children. A beautiful North Carolina study looking at health education, school-based clinics, even offering condoms at school, overall, 96 percent of parents wanted their children to have health education from K through 12. The most conservative group of North Carolina; even that group wanted their children to have health education, health services, and condom distribution in schools.

Mr. BALLENGER. Well, I am glad at least—that 56 percent are probably all mine.

[Laughter.]

Dr. ELDERS. Well, that was the good news. They wanted it.

Mr. BALLENGER. I would like to ask, Dr. Payzant, do you feel that the Department of Education is involved enough in the management of this? I mean the way we read it, the Department of Health and Human Services is going to run this whole kit and caboodle and you all are stuck off to the side somewhere.

Dr. PAYZANT. As I mentioned in my opening remarks, we began with the agreement that we had three options: One, HHS could administer; two, Education could administer, or we could jointly administer. Regardless of which option is taken, we believe that there has got to be close collaboration and working together.

We rejected the joint administration proposal because we thought that that might lead to more overhead costs and some duplication. Then, frankly, decided on having HHS administer it because they have had a little more experience than we have to date in working with infrastructure and networks to do some health education related things. We thought that it would be wise to build on that rather than doing a new startup activity in the Department of Education.

But Education has to be very much involved with technical assistance, making the connection to schools, because we have closer connections than HHS does in most instances.

Mr. BALLENGER. Thank you.

Thank you, Mr. Chairman.

Chairman OWENS. Thank you.

Now that we have had the results of the polls from the great State of North Carolina, we would like to shift to Indiana.

Mr. Roemer.

Mr. ROEMER. Thank you, Mr. Chairman, and welcome, Dr. Elders and Secretary Payzant. We are delighted to have you here and delighted to have the opportunity to ask you some of these questions.

In reading through your statement, Dr. Elders, I am impressed by your footnoting. Not often do we get testimony with reference to footnotes. It reminds me too much of my college graduate school days. But I can tell you are well prepared and ready to answer some of these tough questions.

Let me tell you about the book that I just finished reading, and maybe you have read this, too. It is a book by a journalist from the Wall Street Journal, Alex Kotlowitz, and he writes a story about young children growing up in Chicago in the Henry Horner projects, and the name of the book is "There Are No Children Here," and we are in danger of losing children everywhere throughout this great country if we do not do something about the violence and the drug problem and ultimately the health care problem as well.

The Children's Defense Fund just released statistics last week saying that we lost 5,000 children in the last 14 years to gun violence in this country, as many as we lost in the Vietnam War.

Let me ask the question, what do we do about violence? I have heard you speak out about this. It is directly related to health care, it is directly related to your job, it is directly related to our job as Members of Congress. What roles do the schools have in preventing violence where we have too many metal detectors and dogs sniffing for drugs? What do we do with the school-based clinics? What is your role, and what message do you have for Members of Congress today on the role of government and our community?

Dr. ELDERS. Mr. Roemer, I certainly think the Congress is trying to get guns out of the hands of children by banning automatic assault weapons. We also need to begin to integrate our prevention efforts very early in schools. We have got to teach our young people how to deal with violence in nonviolent ways.

We need not just a prevention effort, not just a criminal justice effort, not just putting them away and forgetting about them; we have got to have all of those efforts integrated together. This is why I feel so strongly about the comprehensive health education program starting very early because, as you already know, it is not just a drug problem or an alcohol problem or a sexuality problem. Usually it is the same children that have a combination of problems. I feel that one of the best things that we can do is to start very early and provide for these children through our Head Start programs and early childhood education programs.

We know children doing well in school are far less likely to get in trouble. We must start with early childhood education, we need a comprehensive, integrated health education program that includes violence prevention. We must also pass laws and apply strategies we used when we found that automobile accidents were killing so many young people. We put driver's education in schools; told the industry they had to make safer cars, including air bags bags and infant seats; and then we told the engineers, you have got to build and design a better highway. I feel that we can't just do one thing, we are going to have to take this comprehensive approach.

Mr. ROEMER. Let me ask for more specifics, Dr. Elders, and then turn to the Secretary after a couple more questions.

We heard the President very, very articulately talk about punishment last night—three strikes and you are out, or three strikes and you are in, however you want to refer to it, for three violent offenses; boot camps, 100,000 police officers on the street, assault weapon bans—we heard him talk as passionately about prevention. What specifically can teachers do when these kids are coming in from rural or inner city schools, when they are being threatened by guns and at knife point? How do they say to these students and children, "My job is not only to teach you math and science, my job is now to teach you about health education and nonviolence?" How do we do that? How do we get the community involved in this effort and not just say that it is the teacher's role?

Dr. ELDERS. I think what you have just said is exactly right.

The entire community has got to be involved, which was one of the things that I worked hard on in Arkansas. Churches, schools, businesses, judges, all of us have to be involved in working on this effort. However, we still must put health education program and violence prevention programs in our schools. We must begin to educate young people who see nothing but violence on TV, nothing but violence in their neighborhoods, nothing but violence in their homes.

Mr. ROEMER. What were the biggest problems you faced? And you talked about it in about a paragraph in your statement when you were in Arkansas trying to set up some of the school-based clinics. Can you take me through some of the biggest problems at the community level?

Dr. ELDERS. I think the greatest problem I faced in Arkansas was ignorance. I had to deal with the community, the church, and with my legislators who told me, "Well, Dr. Elders, we didn't have a problem with teen pregnancy until you became the health director." We had the second highest rate of teenage pregnancy in the United States, and the United States has the highest in the industrialized world. I had to overcome these misconceptions.

I am very proud that Arkansas was one of the States that had 8.6 percent reduction in teenage pregnancy in each of the past two years while the country went up.

I had to get the media involved, and started out with the religious community—my brother is a minister—and asked them to help me. Then I went to the AARP, our elderly, and I asked them to help me. It was really the religious community and the AARP that made it possible. I often say, "If you get a line of men with their collars on and a line of the elderly carrying signs supporting something you don't have to worry about how your legislators are going to vote."

Mr. ROEMER. Don't just get the priests with the collars, get the sisters as well.

Dr. ELDERS. I did.

Listen; the most wonderful telling testimonial I ever had was from a Catholic priest when I was before a group of ministers who got up and said, "We all know what Dr. Elders is about, and you know the doctrines of our church, but I want you to know that we have got a crisis in our community, and that requires crisis intervention, and I support Dr. Elders." Everybody else decided that if he could get up and say that, well, they could too, and I received a great deal of support.

I also received support from our TV media. In fact, one of our local stations won all of the prizes for PSA's that year because they devoted all of their PSA's to the problems of adolescents.

Mr. ROEMER. You might turn to your right and say that to those cameras.

Dr. ELDERS. So I am very grateful.

Mr. ROEMER. Mr. Secretary, let me ask you—and I will end here—coming from somebody that is not known for a record of extravagant spending, having taken on the space station and trying to defeat that, and putting our priorities here on Earth in education, and taken on the advanced solid rocket motor, and beating that—is this enough money? Are we spending enough money on such a vital program? We are looking at $50 million to start off for the country.

Dr. PAYZANT. It is a very good start with respect to comprehensive health education programs; $50 million a year will do a great deal on the targeted areas. We are proposing to help build on what States and local school districts have already begun in health education.

The amount of money proposed for the school-linked health services is substantially more, recognizing that the cost of those services is going to be higher.

I want to come back to another part of the administration's proposal which puts some substantial dollars into what you were talking about in your first or second question to Dr. Elders.

First of all, we have the safe schools bill that we hope will pass soon so that we will be able to take advantage of the modest but important $20 million appropriation to get started with that effort this year to address the issue of violence in our communities that are experiencing the greatest problem with it. Earlier this morning the subcommittee marked up Title IV of the administration's proposal. The substitute bill that Mr. Owens has put in would combine safe and drug-free schools, and I think you heard in the President's State of the Union message last night a bit of an indirect reference to more money for the work that has to go on with violence and drug prevention. We are hopeful that when the President announces his budget in early February that you will see in our ESEA reauthorization bill support for three priorities: Title I, which we have already said will be $700 million dollars more to help all students get to high standards, more money in Title II to help teachers become skilled in their instructional practice in helping all those students get there, and more money in Title IV which will help provide the safe and drug-free kind of environments that all kids have to have if learning is going to take place and they are all going to reach those high standards.

Is it ever enough? No. Is this a substantial commitment and step given the budget situation that we all face today? Yes. I think it is an important step and an important message to the American people to address the priorities that they are telling us are there.

Mr. ROEMER. Well, I am happy to hear your answer.

Let me just conclude by saying that I think with the agenda that we have before us, safe schools, elementary, secondary, Head Start reauthorization, school-to-work, Goals 2000, we have to be vitally sure that we coordinate our programs and make sure we are not duplicative and we are creating disparate programs that don't really reach the intended audience that we want to reach in helping fix our schools and cut down on violence and so forth; and, secondly, I think—and I hope I am hearing good signs from you—that we are going to get more money in the education budget. We come up with a good idea like national service, and that ultimately comes out of our function budget. We have all these good programs, and discretionary spending is going down.

So I will be very, very keenly aware of what we are doing and what we are putting in terms of our resources toward education and reform and new ideas in education and tying that money to initiative for differences. But I will believe more about these new moneys and Chapter 1 and teacher development when I see them, and I hope we are optimistic when the budget comes out, and I thank the Secretary.

Dr. PAYZANT. I would just add, Mr. Roemer, that I am hopeful that there will be additional dollars, and I want to make it very clear that the administration is interested in moving away from "business as usual" and that with additional dollars comes some obligation on the part of all of us to do things differently and better.

Mr. ROEMER. Absolutely. Mr. Secretary, the money is not going to old ways of solving old problems, it is tied to innovation and creation and reform and, as the President said last night, renovating America. But I certainly hope that the money will be there for creativity.

Thank you, Mr. Chairman.

Chairman OWENS. Thank you.

Before I yield to Mr. Barrett for questions, I would like to welcome the Chairman of the full committee, Mr. Ford, and another member of the full committee, Mr. Reed, who have joined us.

Would you like to make a statement, Mr. Chairman?

Mr. FORD. Thank you, Mr. Chairman. If I might impose on you, Surgeon General Elders and Tom, I have just come from a meeting with the chairman of two other minor committees that are sharing with us the responsibility of writing the President's health care bill, the Ways and Means Committee and the Energy and Commerce Committee.

[Laughter.]

Mr. FORD. Please note that I said that with a smile on my face.

We are coming together now after an awful lot of effort in all of these committees, and I want to compliment you, Chairman Owens, for how consistently and persistently you have pursued these issues which will be a part of the consideration of putting together a whole package that is something more than a framework but actually has some substance to it.

These things may seem tedious, but to do anything as dramatic as the President is trying to do and Mrs. Clinton is trying to do with national health care, we have got to make sure that it all makes sense and that it can work. We have a limited amount of experience to which we can point and say this is what will happen. But we do have a sufficient amount of experience to be able to predict with some sense of conviction that it can work and we can make it work.

I would mention to the gentleman from Indiana that I believe there will be meetings with the Secretary and Tom and others very quickly on the Elementary and Secondary Act. Mr. Goodling, I believe, is going to participate on that with us. We are going to start moving the major dollar amount that this committee deals with in the elementary and secondary education very quickly, and Dale Kildee and his subcommittee—and you are a member of it—have done a tremendous job of bringing together this very, very complex package that nobody is going to say is business as usual or the same old stuff just sort of warmed over. It is pretty dramatic and it is dramatic while at the same time it does not raise the hackles on a whole lot of people and frighten them into opposition. It looks like Mr. Kildee, in the tradition of his Jesuit training, has figured a way to dodge the mine field, and we hope that we can come to some understanding with the Republican leadership on this committee and the Department in the next few days that will make it possible for us to move right ahead. I am optimistic that we will have available, maybe not new money, some of it will be new money, but we will have available for education purposes, money that has been going some place else or might have gone some place else if we don't take this action.

So I am optimistic that the administration has found its course in pursuing these things, and I am not at all afraid.

I know Tom is a fiscally conservative person. I have been dealing with him on and off for years. He has had a lot of influence on Federal education policy over a good many years going back to his career in California, and when you were named, Tom, I called my predecessor as the chairman, who is an old friend, Gus Hawkins, and he said, "He is probably the best person we have got in the State of California for that job," and so far we are satisfied that Gus has always known what he was talking about.

I wish I could stay here for the rest of the hearing, Mr. Chairman, but I am trying to run and do all of these things because I promised the President yesterday, before I announced I wasn't going to run for reelection, that we would pass all of this stuff before I left.

[Laughter.]

Mr. FORD. And I have been awake all night making a score sheet of just what kind of a monumental accomplishment that would be. So I have other things to keep stirring, and I want to thank you again for your initiative on this and also for having ready the work that you have been doing on the drug-free schools program; you have got some improvements in there that are long overdue.

Major Owens is one of the people who sets an example of what a real subcommittee chairman ought to be here.

This subcommittee, Major, originally was created for John Brademas, who they always referred to as an eclectic subcommittee chairman because he could find all kinds of ways to get jurisdiction over all kinds of things. I suggested it must have stayed with the subcommittee or goes with the chair. You are doing as good a job as I ever saw John Brademas doing by bouncing so many balls in the air at the same time. But ultimately, before the summer break, it is all going to come together, and there will be a recognizable package of changes in education directly in what people generally think about or traditionally thought about in education and more realistically what the future really is when you talk about education.

You can't talk about education without talking about drugs, you can't talk about education without talking about crime, you can't really talk about education without talking about anything else that is important now or for the future in this country, and Major Owens personifies the subcommittee chairmen on this committee who are proceeding in that way.

This Congress, we have not just taken anything that was up for reauthorization off the shelf and dusted it a little bit and trimmed around the corners and run it back through, we literally have been turning it upside-down, shaking out, examining it, and making ourselves recognize with our pride of authorship that we have got to justify for the future what we thought was adequate in the past. Nobody is doing a better job in that than the Chairman of this subcommittee, and for that I am very appreciative.

And I know that Mr. Goodling would be here if he could. I talked with him late yesterday, and he tells me that his eye operation was a success. I am very happy for that because he will be here this afternoon meeting with us, I believe, which is very fast after you have a new lens put in your eye. They do miraculous things. If I knew that they could keep patching me together the way they are doing with Goodling, I would stay for a while.

Thank you, Mr. Chairman.

Chairman OWENS. Thank you, Mr. Chairman.

Mr. Barrett.

Mr. BARRETT. Thank you, Mr. Chairman.

Mr. Secretary, as I scan both of these bills, it occurs to me that there is $50 million for education and $1.5 billion for the establishment and the operation of the health service sites, as they are called. I guess a very basic question, Mr. Secretary: What would you envision these sites actually doing in health services?

Dr. PAYZANT. I would draw from my experience as superintendent in San Diego where we worked to coordinate services with the other agencies that I mentioned in my testimony. First of all, they would be, as Dr. Elders and I both said, what the community determined they ought to be based on an assessment of that community's needs and the needs of the children there. This could include a broad range of health services that would begin with screening and diagnosis that would then allow for referral to the proper professionals for follow up where there were more complicated health problems that children had. There would be hopefully a coordination with other services that the child might be getting through social service agencies and the schools to eliminate any duplication and overlap.

There would be a prevention component so that you could hopefully catch things early on with children and do sometimes some very simple things that would prevent health problems and greater costs of treatment down the line.

There could be an intake kind of setup for families that were new to the community or school that would look at the needs of the family and make some determinations about who could best serve them. It is going to vary somewhat from community to community, but fundamental health care for children that would not otherwise be available to our neediest young people.

Mr. BARRETT. Who then would be performing these services—doctors, nurses, others? And, if others, could you identify who they might be?

Dr. **PAYZANT**. You would have to have the people performing the services that were well qualified, licensed and under whatever State law exists to provide those services. So you could have physicians, you could have nurse practitioners, you could have registered nurses, licensed practical nurses, health aides, educators, with the services that they provide specifically related to the expertise they have and the necessary licenses required to perform those services, to be a team.

Mr. **BARRETT**. What liability would the schools have in case an illness might be identified and the child had to go elsewhere? Has that been considered?

Dr. **PAYZANT**. Well, it depends on how the school health services are set up. There are a lot of different models. One would be that the school, as part of a community partnership, would decide to set it up and actually be the major overseer, and depending on the arrangement, the school district's liability insurance would cover.

It might be that the school district, if it were involved, would contract with medical professionals or a community-based organization to set up the clinic. At one of our clinics in San Diego, Children's Hospital had a contract and came in; they actually did the billing, their liability insurance covered, and their professionals in Children's Hospital worked in the school-based clinic.

So there are many different models that you can use.

Mr. **BARRETT**. Would a State's scope of practice law remain in effect?

Dr. **PAYZANT**. As far as I know, yes.

Dr. **ELDERS**. Yes.

Mr. **BARRETT**. Dr. Elders, what about a State which has limited medical resources, like mine? There are a lot of small States out there in areas which don't have doctors, which don't have nurses, which don't have health care professionals.

Dr. **ELDERS**. Like Arkansas.

Mr. **BARRETT**. Yes, exactly. Where do we go with that problem?

Dr. **ELDERS**. Well, you know, in Arkansas, our school-based clinics were under the auspices of the health department. We took them on as our liability using multiple sources of funding and used nurse practitioners to do many of the services with referrals to physicians.

However, we also used school health nurses, RNs or LPNs, as Dr. Payzant outlined. It depends on the service.

No school, not even our very largest school, had the same physician there five days a week. We would have different doctors come in for our large schools; while smaller schools may have only had doctors visit one day a week. The nurse practitioners would provide the services in the intervening time. We found these services very effective and helpful to students and parents. In a State like Arkansas, it was a very important asset to the community.

We found that attempts to close school-based clinics for lack of funding were strongly opposed.

Mr. **BARRETT**. So in a small State like Arkansas accommodations have been made; Arkansas could comply with under the terms and conditions of H.R. 3600.

Dr. ELDERS. Oh, yes, we were able to deliver many of the services, but not to all of our schools. Arkansas has 1,200 schools, and we were only providing school-based health services in 24 schools.

Mr. BARRETT. What would this issue say to the student who, because of religious beliefs, precluded him or her from taking advantage of traditional medical services?

Dr. ELDERS. Yes, sir. In all of our schools our parents at the beginning of the school year gave a permission slip. So in that instance, parents would not give permission. And in school-based clinics, we did not provide services in the school-based clinic if parents had not signed a permission slip for the student to use the services. Parents may say the student can use the clinic but they can't use particular services.

So if the parents' religion precluded them from using the service, obviously this would be a student that we would not be able to provide services for in the school-based clinic. However, if it was a serious problem, we would try to locate the parent or try to make referral, or try to do the things that we needed to do to help the student.

Mr. BARRETT. Thank you.

I guess maybe a final question, Mr. Chairman. I have had a lot of input from my constituents who seem to be very concerned that the Federal Government will be overriding locally developed curriculum, and I guess I would ask you to speak to that. Mr. Secretary, you spoke to it earlier, local consideration. Would local curriculum take precedence, or would the Federal law take precedence?

Dr. PAYZANT. The grants that are proposed under the comprehensive school-based health education program would go to States and larger local education agencies initially to give them the opportunity to develop their comprehensive health education programs. The control over the content of what is in those programs, the curriculum, and how it would be taught would be at the State and local level, which it properly should be.

Mr. BARRETT. The question—and you touched on it a moment ago, Dr. Elders—the distribution of condoms or perhaps family planning counseling, if that is not allowed at the local level, what happens then?

Dr. ELDERS. If it is not allowed at the local level, obviously it would not be a part of the school-based health services.

Mr. BARRETT. Thank you very much.

Thank you, Mr. Chairman.

Chairman OWENS. Thank you.

The Chair would like to note that we are quite pleased that we have received so much attention to this hearing, but since we have a total of nine witnesses, I am going to ask the members to try to limit themselves to five to seven minutes in their questioning.

Mr. Miller.

Mr. MILLER. Thank you, Mr. Chairman, and I will do that.

Let me just commend you both and commend the administration for this program.

Earlier in my career here, I chaired the Select Committee on Children and Families and spent a lot of time with people in the early days trying to set up you, Dr. Elders, and others, school-based clinics which have toured school districts that have done that, and seen some of the really dramatic and wonderful results that they have been able to achieve on behalf of young people.

I have two specific questions. One was raised earlier, and that is the focus on the 10- to 19-year-old. In that section, you provide for special consideration to problems such as adolescent pregnancy, sexually transmitted diseases, gang injuries, and exposure to drugs and alcohol.

In a number of areas, we have poor populations that simply may not have gangs, violence, drugs, and a lot of other issues—in some cases they are in rural areas and in some cases they are migratory where the general health of the children is just bad and affects their ability to learn. Either they have long lingering, half-baked pneumonias or a lot of other problems that you have because of housing and general environment. I am not sure that the section really speaks to them. You speak to the medically underserved population. I just wonder also, where you have a population that is fairly well defined, for which the general medical conditions of the children are just not good, we might look at that population in this legislation, too? I mean they may not have a lot of these other indicated problems, which are certainly getting our attention finally, but they just have bad health.

Dr. ELDERS. And they are just poor.

Mr. MILLER. Yes, just because they don't see doctors, they don't have a good diet, and they are not very warm at night.

Dr. ELDERS. Exactly.

I think that the first consideration would be that these funds would be targeted to schools with the highest percent of poverty. Poverty becomes the lead target that gets you. I think that that is really a very critical issue, school-based clinics must provide a whole range of services like nutrition.

You know, there are a lot of Federal programs out there, but many of our poorest people are also uneducated and they don't even know how to access these programs. So many times it is really teaching people how to use what is already available. It really makes a lot of difference.

Mr. MILLER. On that note, in the area that I represent, we have a very highly developed WIC structure, a network of clinics, and we have a very highly developed structure of Planned Parenthood clinics. In one of the counties I represent, I think, Planned Parenthood has taken over running a good portion of maternal and child health functions.

We also have in the other county a very highly developed system of county clinics in the neighborhoods. Tom, many of these are right within walking distance of a number of schools, in some cases high schools and certainly, in a number of cases, elementary schools. Is there any problem with those clinics receiving funds in coordination with county programs or with the WIC program to provide these services?

Dr. PAYZANT. No, not at all.

Mr. MILLER. Some of them are appropriate, and some of them aren't, depending on what parents decide they want their children to participate in. But in terms of the use of dollars, we are engaging in building two additional clinics in very poor neighborhoods in

Contra Costa County, and they are right in the middle of the poorest school attendance area.

Dr. PAYZANT. The point of all of this is school linked, which doesn't necessarily mean school based.

Mr. MILLER. Okay.

Dr. PAYZANT. And another important point is to go to where the children are so that there will be the greatest ease of access to get services.

So to the extent that consortia could be developed, that community-based organizations could be involved, that would be fine. I think access would be a major issue in terms of judging the quality of an application.

Mr. MILLER. I don't want the constituency for school-based clinics to drive all the decisions on funding if you can have school-linked clinics and provide the same services cheaper, better, or what have you.

By the same token, access is the issue. It has got to be easy. One of the things we know about school clinics is that the ease of access is why we get so many of the results that we get with students that we would not have otherwise. Thank you.

Thank you, Mr. Chairman, and thanks for the hearing.

Chairman OWENS. Thank you.

Mr. Fawell.

Mr. FAWELL. Thank you, Mr. Chairman.

I would like to make just some comments and then get your reaction to them. A lot of revolutionary things are happening in education which we all support. We are zeroing in on basic education goals, performance standards, and modes of assessment. We have goals that are well expressed in basic core curriculum, and at the same time in terms of health care in general.

I think no matter what health bill may pass—and Mr. Clinton's health plan may not pass—there are several very sound pieces of legislation out there; Mr. Cooper's bill is very good. Everybody is zeroing in on universality of coverage, and I think you are going to see that. However, there are exceptions in every bill. Under the Clinton bill Congress won't be covered, which is, I think, kind of novel.

But as I look at our efforts on education, I have some concerns about a comprehensive health agenda here, it is rather ironic that it should come in coordination with universality of health care which, for the first time, would mean that everyone under the Federal poverty level or as high as 200 percent thereof is going to have that coverage. The WIC program, and other programs, will be in much better position to provide these services.

So I have this question that undoubtedly when you talk about education, it can cover everything. Obviously, you are not ready to learn if you have deep problems back home. But I tend to think that a lot of us will question whether or not the schools are the best place for all of this, not only education but services.

We are talking about school clinics dealing with suicide, diseases of all types, and violence prevention. The list goes on and on and on. To expect that our schools will once again be tapped to pick up this responsibility, which is tremendously involved, is something that causes me a lot of concern.

I will do a lot of thinking about it, but looking at it strictly from what we have to achieve in the basic core curriculums and what we have to achieve in standards and performance assessments, and considering the revolution that is occurring in health care, is it wise to once again pick on our poor schools to play the central role? Because no matter what we do, there will always be children who aren't in school because they are too young or because of any number of reasons. Perhaps a community-oriented health collaboration, clinic, would be much better formed some place else. Any reaction to that terribly long question?

Dr. ELDERS. You want an immediate reaction all right?

Mr. FAWELL. Yes.

Dr. ELDERS. Comprehensive is a comprehensive health education program. I feel we need to teach young people how to brush their teeth, how to wash their hands, how to eat the proper diet.

Mr. FAWELL. I agree with that. I am just wondering if the school is the best place for this.

Dr. ELDERS. But where else would this occur? I know for your children it will occur at home, but for the children we are having the most problems with—children from poor neighborhoods, children from young parents, teen parents—they don't know how. So I feel that the only place we can reach all of the children is at school. We have got to teach them about all those preventive services, exercise. We have got to teach them about avoiding certain high-risk behaviors, smoking. Currently, children have one class teaching them not to smoke. It is possible to reduce tobacco smoking 37 percent. We have over 400,000 deaths a year related to tobacco smoking.

So I feel that the place to do this is at school. It needs to be coordinated, it needs to be age appropriate, graduated, and it needs to be done year after year. I don't feel that you can educate children that are not healthy, nor do I feel that you can keep them healthy if they aren't educated.

So I feel that the school is the best mechanism that we have got. Where we have our school clinics, we have found that the communities buy into the school clinics, the churches buy in, the businesses buy in. We have a community board that works with our clinics and as the intermediary between the school, the health department, the school board, and the superintendent. This has really been wonderful, and we have not had one school that has not wanted to continue these services. We have found that we have reduced the dropout rate and the teenage pregnancy rate. I think to reduce the dropout rate, to reduce teen pregnancy, is really an asset in and of itself. One of our psychiatrists who attended these clinics felt that it would markedly reduce mental health problems later in life. I am not saying that it does. But what he was saying is, if we see them early, take care of them early, and children feel very strongly that, "This is my clinic," rather than it is mom's or dad's or someone else's.

Mr. FAWELL. Dr. Payzant.

Dr. PAYZANT. My first year as a superintendent was in a small suburban district outside of Philadelphia. Only eight schools and about 4,500 students were in the school district. In those days, some 25 years or so ago, the mission of the school, which has always been and should be an academic one, took most of my time.

When I left the superintendency in San Diego, the Nation's eighth largest school district, in June of last year to come to Washington, I was struggling each month more and more to spend time on the academic part of the mission because there were so many other needs of children that were there, regardless of whether teachers and principals and others wanted them to be there.

My answer is a very pragmatic one. We know there is a connection between health and learning, between the emotional well-being of the child and learning, between all kinds of things and learning. When that child walks across the playground and into the schoolhouse, that teacher has to accept that child as he or she is and not be judgmental about them.

Any good teacher knows that you can't be effective with student achievement if a child is hungry, is emotionally distressed, is cold, and the schools can't do all of that, so we have got to have some strategies for getting at that. If other institutions in the society are not fulfilling their responsibility, I think the answer is finding new ways to coordinate and collaborate on the kinds of services that are going to be provided. So that my fantasy is that teachers ultimately will have the freedom to focus on the academic mission and won't be constantly having to deal with children whose other needs aren't met.

The final thing I would say is, on the pragmatic level, a dream of mine would be that we would have a comprehensive approach to meeting the needs of children in this country, of which education is a major but only one need, and right now advocacy for children best comes in schools. When it comes from other places beyond schools, then, it seems to me, some of the pressure will be off. But a lot of what we are talking about is advocacy for children and meeting their needs, and because the connections are so great and they are in school six to seven hours a day, it seems to make sense to try to work around the school as one of the major places that we can meet that need.

Mr. FAWELL. Well, I thank you both. Time is of the essence here. I still am uncomfortable and have some concerns. I do agree wholeheartedly with you that those services ought to take place. I am not convinced that the schools should be the central place.

The WIC program, oriented family services, and many other programs can provide these services—I think we could do perhaps even better without necessarily giving schools the responsibility. But I thank you very much for your time and appreciate your remarks.

Chairman OWENS. Thank you.

Mr. Reed.

Mr. REED. Thank you very much, Mr. Chairman, and thank you for having this important hearing.

Madam Surgeon General, and Secretary Payzant, welcome.

Secretary Payzant, I had the opportunity to visit something which I think is a prototype of what we are talking about last Friday in Newport, Rhode Island, at the Thompson Middle School where we saw the social service mall, and it impressed me very much.

What also impressed me was the fervor which the teachers, guidance counselors, school administrators, and the school committee representatives who make these decisions displayed about the idea of linking the health services and social services with the educational process.

One reason why I think this is the case is that they see a very clear correlation between educational excellence and these types of services. Secretary Payzant, or Madam Surgeon General, would like to comment further on the real educational benefits of this program, not only because it is a good, decent thing to do, but because it will result in better schools and better educational standards.

So, Mr. Secretary, would you like to start off?

Dr. PAYZANT. Well, you can start with something as basic, Mr. Reed, as attendance. We know that a lot of the problems that young people have with poor attendance are related to health and to conditions at home. The young man that was at Thompson that talked to us about his experience over the last several years—nobody was connecting with him and his issue. It wasn't until something from that mall reached out to him and made that connection that nobody else was able to do that he then became comfortable in dealing with what was putting him off in the school, and helped to get him back into the mainstream. Now, as he told you and me, he wants to go to West Point, and he is determined he is going to get there. This is a perfect example of a turnaround situation.

Mr. REED. Madam Surgeon General.

Dr. ELDERS. I would certainly agree with your observations. Let me share an interesting story. We had a young woman who was coming to school, even though her parents had put her out because she was 18 and they were no longer getting money for her. The student was a senior and a merit scholar at a very large high school, and she was sleeping in a car. This was discovered by the school health nurse in the school-based clinic, who was able to get her in and get all of the local services that were necessary. That student is presently at Stanford.

But she would have just dropped out and nobody would have noticed, except the school nurse noticed that she was coming in for health services. And most of our principals support having a place, a nurse, a clinic, where they can refer young people to and not consume a teacher's time.

A teacher does not have 30 minutes to stop her class to deal with a student's problems even though she knows that they need it. But if she has a clinic or a nurse or someone that she can refer them to, the student can get all of the services that they need. To me, that really would improve the educational process.

Mr. REED. If I can echo your comment, one of the impressions that I had—and the Secretary might comment also—is that there was a very specific, explicit acknowledgment by the teachers and the guidance counselors that they are not prepared to deal with the problems. They have neither the time nor the professional training to do so. Yet, if not by design, then by default, teachers and guidance counselors are overwhelmed by these problems, and simply wishing they will go away won't do anything. In order to allow teachers to teach and young people to learn, we have to get them linked up with professionals who can reach them.

The example that Tom gave of the young man who had some severe problems and now, with such determination—I wish I was determined that way when I was a youth—he wants to go off and be a cadet at West Point. So it shows great judgment too, by the way, to go to West Point.

Thank you very much, Mr. Secretary, and thank you, Mr. Chairman.

Chairman OWENS. Thank you.

Mr. Strickland.

Mr. STRICKLAND. Mr. Chairman, in the interests of time, I have no questions. I would just like to say, as I have sat here and listened to the two witnesses and to the members of this committee, I am glad we are talking about these issues. I think we need to view our schools in a more comprehensive nature perhaps than we have in the past.

I was thinking about my own school experience, having gone to a one-room school my first four years, having a single teacher, and the fact that many of the things that I received in that school students do not or cannot receive in schools today; the kind of personalized attention, the kind of interaction between that teacher and my parents, and the kind of supportive community I had. I do believe that we can't expect children to learn if they are hungry or if they are afraid or if they are sick. So it is a part of the mission of the school to provide these comprehensive services. That being the case, we have got to be serious about how we fund our schools and how we pay for those services.

I am glad you are here today, doing what you are doing.

Chairman OWENS. Thank you.

I want to thank both of our witnesses for being very patient. I don't want to be redundant and ask any further questions, but I may have some additional questions to submit to you in writing.

The basic issue is, after health care reform is achieved, will children in schools be better served with adequate health care and will schools be less burdened? I think that is the thrust of a lot of our questions. Will we take the burden off the schools and provide first-class health care without them having to shoulder that extra burden?

Thank you very much for being here Dr. Elders and Dr. Payzant.

Dr. ELDERS. Thank you, Mr. Chairman.

Dr. PAYZANT. Thank you.

Chairman OWENS. We are going to proceed with our second panel who have waited patiently. We will take one minute for our guests to leave and then we will proceed.

Our second panel consists of Mr. Alan Lubin, executive vice president, New York State United Federation of Teachers, an affiliate of the American Federation of Teachers; Ms. Marilyn Monahan, the secretary and treasurer of the National Education Association; Ms. Roberta G. Doering, a local school board member, Agawam, Massachusetts, and vice president of the National School Boards Association; and Dr. Michael Witucki, associate superintendent, Wayne County Regional Educational Service Agency, Wayne County, Michigan.

Please take seats.

I want to thank you for waiting patiently to give your testimony. Your entire written statement will be entered into the record; you may make additional comments or highlight your statement, but I would like you to limit your remarks to between five and seven minutes. During the question period other things will be brought out, of course, and you will have a chance to elaborate further if you don't get a chance to finish.

We will begin with Mr. Lubin.

STATEMENTS OF ALAN LUBIN, EXECUTIVE VICE PRESIDENT, NEW YORK STATE UNITED FEDERATION OF TEACHERS, WASHINGTON, DC; MARILYN MONAHAN, SECRETARY AND TREASURER, NATIONAL EDUCATION ASSOCIATION, WASHINGTON, DC; ROBERTA G. DOERING, LOCAL SCHOOL BOARD MEMBER, AGAWAM, MASSACHUSETTS, AND VICE PRESIDENT, NATIONAL SCHOOL BOARDS ASSOCIATION, ALEXANDRIA, VIRGINIA; AND MICHAEL WITUCKI, ASSOCIATE SUPERINTENDENT, WAYNE COUNTY REGIONAL EDUCATIONAL SERVICE AGENCY, WAYNE COUNTY, MICHIGAN

Mr. LUBIN. Mr. Chairman and members of the panel, I would like to thank you for the opportunity to speak here today. My name an Alan Lubin. I am the executive vice president of the New York State United Teachers, which is affiliated with the American Federation of Teachers, and I am proud to be representing both groups here today.

We also would like to commend President Clinton and Hillary Clinton for making national health care reform a top priority for our country.

We support the principles and general structure of reform contained in the Health Security Act. We especially welcome your efforts to explore the impact of national health care reform on schools and students. It is this issue alone that I will address today.

As educators, parents, and consumers of health care, our members have a vital interest in these matters. Our national union is affiliated with the AFL–CIO, and we represent over 830,000 members who work in public, elementary, secondary schools, higher education, State and local government, and the health system.

The 2,200 AFT-affiliated unions maintain over 1,900 collective bargaining agreements and negotiate more than 800 new agreements each year. Health care and health care reform has been a subject of negotiations in just about every single one of those collective bargaining agreements over the past few years.

Every day in every classroom in this country, our members see how seriously the health care crisis affects student readiness to learn. Students come to school with many treatable physical and emotional ailments which often go undiagnosed until there is a crisis. Moreover, a large number of children do not see a physician even once during the course of the year.

We see children with health problems that stretch from a running nose without tissues to epileptic seizures without medication for them. We see students in need of suctioning and draining while in school, from children born to addicted parents and getting no help for psychological, physiological, and neurological problems, to children who haven't eaten since they left school the day before. The health situation in schools is closely related to the education that these children are capable of receiving.

We have regular routine pediatric checkups available to some students but not to many. These checkups would help children get the preventative care that they need, which is the bedrock defense against serious illness. However, much of this needed care is not provided because between nine and ten million children in this country have no health insurance. Many whose families do have health insurance do not have well care attached to that health insurance so they cannot get the periodic checkups they need.

These children account for nearly one-third of the total number of uninsured Americans, and this number understates the total number of children who are uninsured at some time during the year as their parents pass from one position to another or lose their health insurance. Ability to pay for health care plays a critical role in facilitating access to health care under our existing system, and that is just plain wrong.

In addition to facing the problems of uninsured children every day, educators are also confronted by an increasing number of children with a variety of handicapping conditions. There has been a rise in the number of medically fragile students in our classroom. There has been, as was stated earlier, students who come to school with many other problems and illnesses that you would not expect to see caused by widespread sexual activity, teenage pregnancy, and school violence.

Although school nurses traditionally have been responsible for providing care to these children, their jobs have been eliminated in many areas due to budget cuts, and care is being passed on to teachers, teachers' aides, and secretaries, none of whom are trained properly to do the medical diagnosis that a medical professional can do.

When I went to school in Brooklyn, New York, in the fifties, there was a school nurse and even a part-time doctor in just about every single school. The children who go to school in Brooklyn now do not have that service, and where they do have it, it is extremely limited, and that is also extremely unfair to the children that we try to teach on a daily basis.

Lack of insurance is only one reason for the lack of access to the health care system. Uninsured children typically lack transportation, translation services, and general education about the need for health care. I was very happy to hear the Surgeon General speak about the need to show children how to handle their own medical problems and how to assist others, but low provider reimbursement for the uninsured, coupled with increased malpractice liability for care givers of high-risk pregnant teenagers, has led to an inadequate supply of providers in low-income neighborhoods. This has led to more low-birth-weight babies, who then become students, resulting in higher medical costs for society.

These problems have focused attention on the need to expand access to health care services for children. As a result of these problems, about 330 school-based and school-linked clinics have been formed in recent years with the goal to providing access to primary care services to uninsured children. Our general opinion of these school-based and school-linked clinics is that they can be successful at expanding access to health care. Success does not appear to depend on where the clinics are physically located; it can be on site, and it can be easily accessible. Nor is success dependent on school management and administrative control. In fact, we believe that educators should concentrate their efforts on educating students and let school nurses and other professionals deal with their specific health care needs. The teachers and the health care providers can work in tandem to provide appropriate medical care for the children.

However, several other important conditions must be met, and they are: Leadership from State and local government to make children's health an ongoing priority issue in each community; community involvement and control over the offered services, use of funds, and placement of the specific health clinics; necessary funding for staff and space; collaboration and training for teachers and administrators to help them recognize symptoms of depression, mental and physical abuse, and other illnesses; and, the role of the school nurse as the key link between the student, the classroom, the health clinic, and the other providers of care.

We believe that schools should be reimbursed for rent, utilities, and maintenance services, and that the entire budget should not come out of the current school area of responsibility.

The Health Security Act addresses many of the problems associated with children's health care needs. Probably the most important provision contained in the bill is that of universal access to a defined set of fully covered preventative health, vision, and dental services. Coverage for acute illness, mental health services, maternity care, and prescription drugs will also greatly benefit our young people. Our children deserve no less, and the AFT supports this provision completely.

There are many other aspects of the President's plan that we support, and they are contained in our statement. I will just briefly summarize. We support the call for all Medicaid recipients and uninsured citizens to be included in the alliances and to receive care on the same basis as employers, employees, and the self-employed. Including these groups in the alliances will provide access to the funding that can care for our children's health needs. Ultimately, we believe that all citizens should participate in and receive care through the health alliance structure. This is the best way to stop cost shifting and provide uniform benefits for everyone.

We support the public health initiatives contained in the Health Security Act that are aimed at improving access and delivery of care to children, and we applaud their inclusion.

The proposal to provide comprehensive health care education in grades K through 12 is particularly important to the health and health educational development of children. Children need to learn to how to take care of their bodies, how to prevent illness, how to prevent disease. The funding of this proposal ought to be considered a down payment on attaining this goal.

Existing school-based and school clinics should be funded and evaluated through the year 2000. The AFT would be happy to work with the committee and others in the evaluation process. New clinics should be approved by the health alliance.

School nurses should be designated as an essential community provider and be paid on the same basis as other health plan providers in different health plan settings.

Ultimately, health alliances must be responsible for developing special care sites, transportation, translation, and other services that are needed to provide access to health care for the populations that they serve.

Alliances should be required to report on their effectiveness in serving the need of children and adolescents on an annual basis. They should collect information on the services provided by the health plans to children and make it available to consumers during the annual open enrollment period. Alliances and/or approved plans that fail to address the health care needs of children should have their charters revoked.

We expect that State governments will be saving big money on this program, and we would hope that the State governments would be required to share their savings from health reform with local governments and school districts who may not be as fortunate.

If health care reform causes a local government unit or school district to increase its funding for health care, the State should pick up this additional cost and keep the unit whole. This provision will enable local governments and school districts to maintain existing services without budget cuts or tax hikes.

These hearings are an important step towards providing universal access for all Americans, and we at the AFT, NYSUT, applaud you for taking the time to listen to us and pledge to work with you throughout this very tough campaign this year.

[The prepared statement of Mr. Lubin follows:]

TESTIMONY OF ALAN B. LUBIN
EXECUTIVE VICE-PRESIDENT, NEW YORK STATE UNITED TEACHERS
BEFORE THE SUB-COMMITTEE ON SELECT EDUCATION AND CIVIL RIGHTS OF THE COMMITTEE ON EDUCATION AND LABOR
JANUARY 26, 1994

Mr. Chairman, I am Alan B. Lubin, Executive Vice-President of the New York State United Teachers, (NYSUT). NYSUT is affiliated with the American Federation of Teachers, and I am proud to be representing both groups at this hearing today. NYSUT and AFT commend President and Mrs. Clinton for making national health care reform a top priority for our country. AFT supports the principles and general structure of reform contained in the Health Security Act. We especially welcome your efforts to understand the impact national health care reform will have on schools and students. As educators, parents and consumers of health care, our members have a vital interest in these matters.

The AFT is a national union affiliated with the AFL-CIO. We represent more than 830,000 members who work in public elementary and secondary schools, higher education institutions, state and local government, and the health care field. The 2,200 AFT-affiliated local unions maintain over 1,900 collective bargaining agreements and negotiate more than 800 new agreements each year.

The health care crisis affects many aspects of our members' lives. As bargainers and consumers, our members have had to either accept more cost sharing, fewer benefits and less coverage or smaller wage increases just to maintain health insurance for their families. As educators, our members see firsthand the impact the health care crisis is having on student readiness to learn. They already know what others are beginning to find out: Education and health are intertwined and improvements in one are not possible without improvements in the other. Congressional support for universal access to health care and real cost containment will help our members reach more children and improve their own economic security.

Because of our beliefs, delegates to our 1990 convention adopted a resolution, "The Future of Health Care," which sets out basic principles that should be incorporated in any health care reform plan. These principles include universal coverage, real cost containment, improvements in the quality of care, administrative simplification and choice of provider. A copy of the resolution is attached to this statement for your review and consideration. The principles our union developed almost four years ago are consistent with the principles advanced in HR. 3600 (and S.1757), the Health Security Act.

Every day, in every classroom in this country, our members see how seriously the health care crisis affects student readiness to learn. Students come to school with many treatable physical or emotional ailments which often go undiagnosed until there is a crisis. Moreover, a large number of children do not see a physician even once during the course of a year.

Regular, routine pediatric checkups would help children get the preventive care they need, which is the bedrock defense against serious illness. However, much of this needed care is not provided, because 10 million children in this country have no health insurance. These children account for nearly one-third of the total number of uninsured Americans. And this number understates the total number of children who are uninsured at some time during the year. Ability to pay for health care plays the critical role in facilitating access to health care under our existing system.

Children are more likely to be uninsured if they are from a low-income family, their parents work for a small employer or are self-employed, or they reside in a central city or rural area. Children who do not have insurance are less likely to have a regular, ongoing relationship with a pediatrician; have fewer visits for acute-care illnesses; and are less likely to be immunized. Moreover, teenagers from low-income families, who become pregnant, are less likely to receive adequate prenatal care.

In addition to facing the problems of uninsured children every day, educators are also confronted with the increasing number of children with a variety of handicapping conditions. There has been a rise in the number of "medically fragile" students in the classroom. These children require catheterization, tube feeding, injections, or oral medications to maintain body functions. Add to this list the high-risk behavior of teenagers relating to drug and alcohol use, suicide, widespread sexual activity, teen pregnancy, and school violence that have not received the focused medical attention they deserve. Although school nurses traditionally have been responsible for providing care to these children, their jobs are being eliminated due to budget cuts, and care is being passed on to teachers.

Lack of insurance is only one reason for the lack of access to the health care system. Uninsured children often do not have transportation to the health facility or physician's office, adequate translation services for non-English speaking children or general education about the need for health care. Moreover, low provider reimbursement for the uninsured, coupled with increased malpractice liability for caregivers who work with high-risk pregnant teenagers, has led to an inadequate supply of providers in low income neighborhoods.

Many of these problems have focused attention on the need to expand access to health care services for children. In an effort to address these problems, about 330 school-based and school-linked clinics have been formed in recent years with the goal of providing uninsured children better access to primary care services. These 330 only cover about two percent of all school districts and less than one percent of all K-12 students.

The typical school-based clinic provides primary health care on school property to the enrolled student body of a high school. The school-linked clinic generally provides the same services to students of more than one school and is located off site. The services offered by these clinics usually include general primary care, routine and sports physicals, lab tests, and diagnosis and treatment of minor injuries. The psychological and social needs of children are addressed through mental health and family counseling, nutrition and weight-loss programs.

Reproductive health services -- which include testing, diagnosis and treatment of sexually transmitted diseases, and gynecological exams -- are performed less often and generally require school and community support before being offered. This is also true of family-planning services which engender the most controversy surrounding the implementation of school-based and school-linked clinics. Health services provided at the clinics generally are provided at no cost to students or their families.

Most clinics are administered either by public or private organizations, such as state and local health departments, community and migrant health centers, hospitals or medical schools. Only a small number of clinics are administered by school districts. According to the Center for Population Options' 1991 Update School-Based and School-Linked Clinics, most funding for these clinics is provided by state health agencies, city and county government, Title V of the Social Security Act, (Maternal and Child Health block grants), and private foundations. The average budget for a school-based clinic is about $100,000 and the budget for a school-linked clinic is about $200,000. School-based clinics generally cost less to operate because the schools donate space, utilities and maintenance services.

Clinics usually are staffed by part-time physicians, physicians' assistants or nurse practitioners. Mental health workers and social workers generally are available to students as well. School nurses often serve as the link between students and clinics. School nurses perform initial screenings, make referrals, provide follow-up services, serve on policy boards and participate in clinic meetings. In some cases, the school nurse also serves as the clinic manager.

School-based and school-linked clinics are relatively new entities, so their ability to expand access to care for uninsured children has not been fully evaluated. The average school-based clinic has been in place for about four years and the school-linked clinic for three years. Preliminary findings from clinics in New Mexico, Oregon and Maryland are promising.

The Association of Maternal and Child Health Programs' February, 1993 report, Opportunities for Enhancing Preventive and Primary Care Through School-Based Health Centers: Three States' Title V Program Experiences states that students are enthusiastic about the programs and participate in high numbers. In Albuquerque, some medical students from the University of New Mexico were enthusiastic enough about their work in the school-based clinic to specialize in primary care medicine.

Our general opinion of school-based and school-linked clinics is that they can be successful at expanding access to health care for uninsured children. Success does not appear to depend on where the clinics are physically located: Both on-site and off-site clinics work. Nor is success dependent on school management and administrative control. In fact, we believe that educators should concentrate their efforts on educating students, and school nurses and other professionals should deal with students' specific health care needs.

However, several other important conditions for a successful program must be met. There must be: 1) leadership from state and local government to make children's health an ongoing priority issue in each community; 2) community involvement and control over the offered services, use of funds and placement of each health clinic; 3) necessary funding for staff and space; 4) collaboration and training for teachers and administrators to help them recognize symptoms of depression, mental and physical abuse, and other illness; and, 5) role of the school nurse as the key link between the student, the classroom, the health clinic and other providers of care. We also believe that schools should be reimbursed for rent, utilities and maintenance services provided on school grounds. AFT resolutions on comprehensive school health programs and childhood immunizations are attached to this testimony for review.

The Health Security Act addresses many of the problems associated with children's health care needs. Probably the most important provision contained in the bill is that of universal access to a defined set of fully covered preventive health, vision and dental services. Coverage for acute illness, mental health and substance abuse, maternity care and prescription drugs will also greatly benefit all young people. Our children deserve no less, and the AFT supports this provision completely.

We also support the call for all Medicaid recipients and uninsured citizens to be included in the health alliances and to receive care on the same basis as employers, employees and the self-employed. Including these groups in the alliances will provide access to and funding for children's health needs. Ultimately, we believe that all citizens should participate in and receive care through the health alliance structure. This is the best way to stop cost shifting and provide uniform benefits for everyone.

Many of the public health initiatives contained in the Health Security Act are aimed at improving access and delivery of care to children, and we applaud their inclusion. We particularly support those public health initiatives that promote good health and the prevention of disease, expanded access to health services, development of qualified community providers, enabling services, mental health and substance abuse grants, and capital development loans. The AFT recommends that teachers, school nurses and their collective bargaining representatives be included in the grant application, implementation and evaluation process.

The proposal to provide comprehensive health care education in grades K-12 is particularly important to the health and educational development of children. Establishing a national framework for school health education will help focus attention both on education and health goals for the year 2000. The proposal could be stengthened by permitting two or more school districts to apply for a grant if their combined enrollment meets the 25,000 student threshold. Again, we recommend that teachers, school nurses, and their collective bargaining representatives be included in the grant application, implementation and evaluation process.

We understand that a school-based or school-linked clinic can be designated as an "essential community provider" under the Health Security Act. Once this designation is attained, the clinic can elect to participate in any approved alliance health plan it chooses. The construction of this important provision would be enhanced if the "essential community provider" were required to contract with every approved alliance plan. This would make access to the clinics available to all children and not just those whose health plan has a contract with the clinic. Alternatively, a health alliance could establish appropriate school clinics and require all health plans to participate in the finance and delivery of care.

Because these school-based and school-linked clinics are relatively new entities and have not been evaluated fully, we recommend that part of the five-year funding appropriation be used for this purpose. We also recommend that the health alliances be required to determine the need for and location of any new clinics created after the Act is passed. The AFT would be pleased to work with the Committee and others on the evaluation process.

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Health alliances should be held responsible for determining overall medical provider and health service needs for the populations they serve, and for developing appropriate responses to these needs. Alliances should work with approved health plans to develop special-care sites, transportation, translation and other needs of their underserved populations. Alliances should be required to report annually on their effectiveness in serving the needs of children and adolescents.

Health alliances should be required to collect information on the services that health plans provide to children and the alliances should make this information available to consumers during the annual open-enrollment period. Examples of the type of information that should be provided include: the percentage of children in each plan who were immunized during the year; the percentage who contracted common diseases such as measles, mumps and chicken pox; and the percentage who were seen at least once by a doctor, dentist or optometrist. Alliances and/or approved plans that fail to address the health care needs of children should have their charters revoked by state government.

The school nurse ought to be designated as an "essential community provider" and be paid through the alliance premium structure on the same basis as other providers who work in other health plan settings. School nurses play a valuable coordinating role between the student, classroom, home and health care system. School nurses provide direct care in the school for routine health assessments, minor accidents and illnesses, triage for more urgent care, and the direct delivery of medical care to "medically fragile" children and children with other chronic long-term conditions. By working in close consultation with attending doctors and parents, school nurses are familiar with the student's health needs. And school nurses communicate problems to the classroom teacher. They are the school's link to the health care system. Designating the school nurse as an "essential community provider" will improve the access to and delivery of health care services to children.

State governments will likely gain a windfall savings due to Medicaid and Alliance premium caps, transfer of a large portion of their early retirees health costs and the two-worker discount. We believe that states should share the savings with local governments and school districts that may not be as fortunate. In that regard, we propose that state governments be required to transfer savings resulting from the Health Security Act to any local governments and school districts that have to increase their health care payments as a result of this Act. The minimum amount a state should share with each local government unit would be the difference between the cost of health care after the Act is in effect and the cost of health care prior to the Act.

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THE FUTURE OF HEALTH CARE*

WHEREAS, union members have historically enjoyed comprehensive health coverage requiring little or no personal financial contribution, but spiraling health care costs have resulted in efforts by employers to shift costs to employees through higher deductibles, co-payments and diminished coverage; and

WHEREAS, efforts by the federal government to control health care costs have restricted hospital admissions to acutely ill individuals and significantly shortened hospital stays; and

WHEREAS, a severe shortage of health professionals affects their ability to deliver the quality of care patients deserve and ultimately affects the health and well-being of society as a whole, the leadership of FNHP requested that the AFT executive council appoint a Task Force on the Future of Health Care to analyze current conditions, explore proposals and make recommendations; and

WHEREAS, the Task Force formed in July 1988 conducted an extensive investigation through presentations by policy experts who focused on the issues of cost, access and quality.

The Task Force found that:

Health care costs in the U.S. have risen from 7.2 percent of the gross national product in 1972 to 11.2 percent in 1987. On the other hand, countries with nationalized health care have been far more successful in controlling their health care costs. For example, in 1970, Canada finalized implementation of its national health care system. Their costs rose from 7.2 percent in 1970 to 8.6 percent in 1987. Other industrialized nations like Japan, France, Germany and Great Britain have kept costs in the range of 6.1 to 8.6 percent also. Health care spending in the U.S. has become disproportionate to the percentage of spending for both education and defense, which has, in fact, dropped from 1970 to 1987.

Increased spending on health care has not brought coverage to more citizens. Some 30 million to 37 million Americans are uninsured, and over 50 million are underinsured and would be made bankrupt by catastrophic illness. Of those uninsured, approximately two-thirds are employed or dependent on someone who is but have no coverage through their job. One in five is a child.

Federal provisions for the poor and elderly, Medicaid and Medicare, have been less than adequate. Bureaucratic processes make application for Medicaid difficult, and stringent rules have left the "working poor" unable to qualify for health coverage. In addition, nearly 46 percent of Medicaid dollars are now being spent to finance long-term care. Seniors spend 18.2 percent of their income to compensate for what Medicare does not cover.

Geographic maldistribution of health care facilities and health professionals is significant in many rural and some urban areas and impedes access to care for those residing there. In addition, cultural differences and language barriers also result in access problems.

Although the U.S. spends more than any other nation on health care, many question the quality of care purchased for the health care dollar. Infant mortality in the U.S. is higher than in any other industrialized nation.

American medical care also lacks standard treatment protocols. Medical practices vary from physician to physician and state to state. Data are now being collected to help define the practices that yield the best results and also monitor the cost effectiveness of various treatments. Early information shows that high cost is almost always an indicator of inappropriate or excessive treatment. Shortages of health professionals have forced hospitals to close beds or use personnel inadequately trained to deliver care.

National surveys show that Americans strongly support sweeping reform. This conclusion has also been reached by the Task Force on the Future of Health Care, and the resolves that follow comprise statements of principles and strategies believed to define cost-effective, high-quality health care for all Americans.

RESOLVED, that the AFT endorse reform of the health care system that encompasses the following principles:

Health care cost containment is a priority and should be accomplished by:

- **establishing a single payment system for all basic services to prevent cost shifting and reduce administrative expenditures;**
- **setting national caps on health care spending;**
- **monitoring and eliminating duplicative or unnecessary services and technologies on a national, state or local level;**
- **establishing a national data bank to collect and disseminate information on health care costs and quality and on the cost effectiveness of treatments and medications;**
- **encouraging and reimbursing preventive care;**
- **providing incentives that reward health care providers and health care systems that demonstrate they can deliver high-quality, cost-effective care;**
- **establishing state coordinating bodies comprising consumers, unions, businesses, ethicists, providers and government to create and monitor incentive programs and quality indices and coordinate capital investment and expenditures based on community needs;**
- **focusing resources on health promotion, health education and disease prevention to reduce illness, high-risk behavior and unnecessary institutionalization; and**
- **supporting safe and healthy workplaces and strategies for environmental protection and cleanup.**

Uniform high-quality health care services are vital and should be accomplished by:

- **recruiting adequate numbers of health professionals to maintain the ability to deliver high-quality care;**
- **collecting and publicly disseminating data on treatment outcomes, by facility and by practitioner, and consumer attitudes about their quality of life after medical treatment;**
- **establishing standards of medical practice and clinical guidelines to be used as a basis for high-quality health care and as a means to reduce the incidence of malpractice;**
- **promoting systems of managed care and case management that monitor and coordinate care of individuals to reduce fragmentation of services, ensure access and control costs;**
- **preserving consumer freedom of choice of providers and setting of care; and**
- **promoting health education as an integral part of any treatment or intervention, as a means to foster appropriate behaviors that prevent or reduce illness and provision of health education should be encouraged in community settings, through the media, in the schools and workplaces.**

Individuals should have universal access to a basic national standard of high-quality care including preventive, acute, prenatal, mental health, long-term and rehabilitative care and drug therapies prescribed as part of the treatment. Such access should be fostered by:

- **eliminating financial barriers to care;**
- **promoting expansion of existing community-based health centers and development of new centers for use by all consumers;**
- **promoting utilization of nurses and other health professionals as primary providers;**

- ensuring portability of health care coverage and providing protection when moving between jobs or states;
- providing financial incentives such as loan forgiveness or free education to ensure adequate supply of health professionals especially in underserved or shortage areas;
- encouraging health systems that improve access through flexible hours and by providing both transportation and child care services;
- supporting mobile clinics and school and workplace clinics;
- providing translation services in any health care setting where English is not the primary language and providing cultural awareness training for health professionals;
- providing broad based programs to pay for long-term care that will not require spending down of personal assets;
- supporting home and community based alternatives to institutional long term care available to all ages;
- supporting long term care eligibility requirements other than individual inability to perform three legislatively defined activities of daily living;
- providing training, support and respite care for family members and others participating in home care; and
- supporting health care systems that demonstrate high retention and job satisfaction rates for health professionals and health care workers; and

RESOLVED, that the AFT prepare educational material for members regarding problems with the health care system and the need for national reform; and

RESOLVED, that AFT update its material on negotiating health care benefits and cost containment; and

RESOLVED, that AFT research the impact on the education system of skyrocketing health care costs and declining health status of children; and

RESOLVED, that AFT continue its support of the AFL-CIO strategies for national health reform; and

RESOLVED, that AFT develop its own grassroots campaign to educate and involve members in change; and

RESOLVED, that AFT research the impact of the severe nursing and allied health professional shortage on the quality of health care services; and

RESOLVED, that AFT create a committee on health care reform comprising representatives from all AFT divisions to provide guidance on methods to reduce health care costs and reform the health care system. (1990)

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[*] This resolution incorporates a summary of the findings along with the complete recommendations of the Task Force. The entire Task Force report was adopted by the council as a resolution at its April 1990 meeting.

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1992 AFT Resolution

COMPREHENSIVE SCHOOL HEALTH PROGRAMS

WHEREAS, recent findings of the National Commission on the Role of the School and the Community in Improving Adolescent Health, the Carnegie Council on Adolescent Development, the National Commission on Children and others have concluded that American children face unprecedented risks to their personal safety and health; and

WHEREAS, the major threats to the health of American children involve behavior choices, environmental, social and economic circumstances and, therefore, may be preventable through timely intervention and medical attention; and

WHEREAS, one in ten – more than 1 million – American teenage girls becomes pregnant each year, double the rate of any other industrialized nation; and

WHEREAS, the Centers for Disease Control estimates a three-fold increase in the rate of sexually transmitted disease among teenagers over the past three decades; and

WHEREAS, according to the American Medical Association, adolescents are sexually active at younger ages, so that 17 percent of girls and 29 percent of boys have had sexual intercourse by age 16; and

WHEREAS, young adults account for 20 percent of all people with AIDS, indicating that many, if not most, had contracted the virus while still in their teens; and

WHEREAS, alcohol-related automobile accidents are the leading cause of death among all adolescents, killing 10 teenagers every day; and

WHEREAS, drug and tobacco use by children remains at dangerously high levels; and

WHEREAS, school-age children face threats of serious violence in their daily lives, as an estimated 135,000 American students bring guns to school on any given day, and at 40 deaths per 100,000, homicide is the leading cause of death among minority youth in the 15- to 19-year-old age group; and

WHEREAS, every year 2 million new cases of child abuse are reported to authorities; and

WHEREAS, suicide is the second most frequent cause of death among teenagers, with one in 10 boys and nearly one in five girls having made at least one attempt to take their own lives; and

WHEREAS, mental disorders are the major cause of disability among teenagers; and

WHEREAS, an estimated 20 percent of school-age children and 23 percent of preschoolers live in poverty, and 15 percent of all school-age children have no health insurance coverage whatsoever; and

WHEREAS, despite the fact that the leading threats to children's health involve behavioral choices and, therefore, may be prevented through education, intervention and the timely provision of direct services, the National School Boards Association estimates that as few as 5 percent of this nation's schools provide comprehensive school health programs, and the Carnegie Council on Adolescent Development concludes that throughout the United States there exist fewer than 330 school-linked or school-based clinics serving less than 1 percent of all adolescents; and

WHEREAS, these threats to the health of children adversely affect their attendance at school, their readiness to learn and their capacity to grow and thrive and become healthy, productive and contributing adults:

RESOLVED, that the AFT encourage and support federal legislation to expand and fund comprehensive school health programs that provide health education and direct services to promote good health and prevent HIV, AIDS, sexually transmitted diseases, drug, alcohol and tobacco use, violence, and other life-threatening and risky behaviors; and

RESOLVED, that the AFT support federal legislation to expand and fund school-based and school-linked mental health and counseling services, health screening, immunization programs, parent skill instruction, crisis intervention, child care and health and social support programs; and

RESOLVED, that AFT reaffirm the role of the school nurse in the planning and delivery of any school-based health care and acknowledge that the presence of any additional services at the school site should not be interpreted to diminish or eliminate the role of the nurse within the school or as liaison to other health care providers; and

RESOLVED, that AFT continue to provide leadership in efforts to remove economic barriers to medical access for all children, including the expansion of Medicaid and other federal programs to finance direct services provided in school-based and school-linked clinics, as well as the enactment of universal health coverage for all Americans.

(1992)

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1992 AFT Resolution

CHILDHOOD IMMUNIZATIONS

WHEREAS, the incidence of some preventable childhood diseases has risen dramatically in recent years. A case in point is measles. Reported cases of measles in 1989 increased 423 percent from 1988 figures with 41 measles-associated deaths reported in that year. The incidence of measles continues to climb; and

WHEREAS, the outbreak of many childhood diseases occurs among unvaccinated children in large urban areas; and

WHEREAS, large numbers of children go unvaccinated because of critical [illegible] in health care and/or lack of access to health care; and

WHEREAS, the federal government has failed to guarantee the availability of measles vaccine to large community clinics; and

WHEREAS, large numbers of recently arrived immigrant children are at high risk of hepatitis B:

RESOLVED, that the Congress appropriate adequate funding to guarantee that all children be vaccinated according to the latest guidelines of the Advisory Committee of Immunization Practices (ACIP); and

RESOLVED, that the federal government through the Centers for Disease Control and the Food and Drug Administration ensure that adequate supplies of vaccine be available at all times; and

RESOLVED, that during outbreaks, unimmunized employees of schools, public institutions and health care facilities be offered voluntary screening and immunization programs. (1992)

Chairman OWENS. Thank you.

Ms. Marilyn Monahan.

Ms. MONAHAN. Thank you, Mr. Chairman and members of the committee. I am Marilyn Monahan, the secretary/treasurer of the National Education Association, and I am grateful for this chance to speak about an issue that profoundly affects all Americans, our health care system.

Over the past several months, much of the emphasis in the health care reform debate seems to have been focused on the elements of coverage: How will individuals be covered, what conditions and treatments will be covered, which entities will be required to pay what share for the coverage. All of these are essential elemental issues and issues of intense concern to our members as well as to all Americans. But today I would like to focus my remarks on the relationship between health care and education and the need for a well structured, coordinated, and adequately funded network of programs to address the health care needs of America's children.

Some will say, probably citing slower growth in health care costs, that there is no crisis in health care. On the contrary, as any teacher in America's public schools can attest, there is a crisis. The number and severity of treatable problems that children bring to the public school classrooms each day is alarming. Members of this committee know well that the problems of poor nutrition, inadequate health care, and threats ranging from physical violence to environmental hazards have worsened over the past two decades.

The deficiencies of care are so great and the gaps in available services so wide that simply creating larger risk pools or providing greater tax favors will only make it harder for many Americans to get appropriate health care. We cannot afford to delay, nor can we take half measures and hope for the best.

The flaws in our present system are fatal. The gaps in service, rising costs, and the precarious nature of a system where families can lose access to medical attention at the time they need it requires immediate attention.

Often unnoted though is the direct relationship between the increased costs of health care and the decrease in financial support for public education. Over the past decade, Medicaid, as a share of total State budgets, has outstripped support for higher education. At its present rate, total State and local health care costs, including direct services and the costs of providing health care coverage of public employees, may well outstrip spending for elementary and secondary education.

We can create a better balance between health care and education. Part of that balance involves creating a more efficient system for assuring children's health care needs are met. In the present system, because of benefit cuts, denial of coverage, and the exorbitant cost of individual coverage, children are less likely to be covered and less likely to get regular treatment or access to preventive services where necessary and all for simple conditions.

Poor health is a primary obstacle to achieving the national education goals, especially the first of the goals, readiness to succeed in school and beyond. Universal coverage to comprehensive health services should be the right of every American.

Among the features of the Health Security Act that we believe should be in any final health care reform plan enacted this year are the provisions to provide $1.5 billion over five years for new, integrated school-based clinics run by educators, health officials, and parents; and, provisions providing additional resources for planning comprehensive school health programs.

Education employees, including teachers and school nurses, already play a key role in identifying children's health care needs and coordinating access to appropriate services. Under these provisions, schools would play an even more significant and ultimately productive role in promoting wellness among children. Such programs must be integrated with other health services in the community, and teachers must have input in the design and in the implementation.

NEA believes a comprehensive program of school health education and services must include school health services, school health education, a safe and hazard-free school environment, integrated school and community health promotion efforts, physical education programs, nutritious food services, school counseling, and wellness programs for faculty and staff.

Increasingly, the danger to children's health comes from behaviors rather than infectious agents, and I believe the testimony offered by Dr. Elders supports that statement. A healthful environment in our schools can help promote lifelong wellness habits that will reduce our reliance on expensive treatments down the line.

Approximately 20 percent of all children and adolescents have a diagnosable mental disorder, but only about 6 percent receive some form of mental health care. About 5 percent of children suffer from severe mental disorders, and only three-fourths of them receive adequate care. Appropriate mental health services must be an element of any final health care reform package.

The longer we ignore the problems of children and families, and the longer we delay affirmative steps towards solutions, the more difficult these issues become. It is imperative that substantive, meaningful health care reform be enacted this session.

There are a number of fundamental measurements by which any plan that is finally adopted must be judged, and we have delineated our own principles which I have attached to our prepared statement that you have before you, but allow me to summarize some of the key points.

National health care reform must provide universal coverage to a comprehensive package of health care treatment and services, and it must bring about significant cost containment. Of the bills introduced so far in this Congress, only the Health Security Act and the American Health Security Act meet the national need for universal coverage and comprehensive treatment and services. Only these two include reasonable provisions for cost containment.

NEA members subscribe to the idea that the greatest efficiencies can be achieved through a tax-supported, single payer health care network. A single payer system, in our judgment, is the simplest system, offers the most options for individual choice, and is best able to bring about cost containment without diminishing the quality of service, and has the greatest potential for economies of scale.

Current public-run health insurance plans spend only one 17th as much on administrative costs as private insurance companies. Moreover, a universal single payer plan has the ability to provide true health security for all Americans. Universal coverage under a comprehensive package of treatment and services, as envisioned in the Health Security Act and the American Health Security Act is the opposite of rationed health care. In fact, the present health care system rations access to health care according to income, preexisting conditions, the nature of one's employment, and other factors that have no rational link to need. Moreover, this type of universal coverage to comprehensive treatment and services expands choice for millions of Americans without significantly limiting the choices now available to those who benefit most under the present system.

Naturally, NEA members, like all Americans, are concerned about the impact of any final proposal on them and on their families as health care participants. We believe there should be parity in the treatment of public and private employees and employers in features such as the proposed cap of 7.9 percent on employer premiums and the exemption for existing plans that are analogous to the proposed health care alliances. We believe collective bargaining rights should be preserved to assure consumer protection, quality assurance, and out-of-pocket cost containment.

Our members have a growing recognition that the current system is unsustainable. They have felt the rise in health care costs directly in a number of ways, through increased out-of-pocket costs, limitations in coverage, and the competition at the local and State level for public expenditure for health versus education.

We recognize the need for greater personal responsibility both in behaviors that affect health and in terms of being active partners with school board and State officials in addressing problems in our health care system. NEA pledges to you the same type of cooperation with Congress as it works to shape a final health care plan that will address the Nation's health care needs, especially as it affects children. Together I believe that we can advance the national education goals and achieve the quality health care system that is second to none at the same time.

Thank you.

[The prepared statement of Ms. Monahan follows:]

Marilyn Monahan

Mr. Chairman and Members of the Committee:

I am Marilyn Monahan, Secretary-Treasurer of the National Education Association. I am grateful for this chance to speak about an issue that profoundly affects all Americans -- our health care system. NEA members have a unique perspective on the issue of health care. As educators, we are concerned about the gaps in the present system and the impact those inadequacies have on public school students. As individuals committed to enhancing the quality of public education, we are concerned about the growing share of our nation's resources that health care costs consume, especially as they detract from governments' ability to provide adequate resources for education. And as public employees, we have experienced the same challenges as other middle-income Americans in being able to afford adequate coverage for ourselves and our families.

Over the past several months, much of the emphasis in the health care reform debate has focused on elements of coverage -- how will individuals be covered, what conditions and treatments will be covered, which entities will be required to pay what share for coverage. These are essential, elemental issues -- issues of intense concern to our members as they are to all Americans. But today, I would like to focus my remarks on the relationship between health care and education, and the need for a well-structured, coordinated, and adequately funded network of programs to address the health care needs of America's children.

Some will say -- citing slower growth in health care costs -- that there is no crisis in health care. On the contrary, as any teacher in America's public schools can attest, there is a crisis. The number and severity of treatable problems children bring to the public school classrooms each day is alarming. Members of this Committee know well from your study that the problems of poor nutrition, inadequate health care, and threats ranging from physical violence to environmental hazards have worsened over the past two decades. The deficiencies of care are so great and the gaps in available services so wide that creating larger risk pools or providing limited tax favors will only make it harder for many Americans to get appropriate health care.

We cannot afford to delay, nor can we take half measures and hope for the best. The flaws in our present system are fatal -- the gaps in service, rising costs, and the precarious nature of a system where families can lose access to medical attention at the time they need it most.

Health Care, Children, and the Future

Of the 37 million Americans with no health care coverage, at least 8.5 million are children. Inadequate health care coverage is a serious obstacle to meeting the National Education Goals, particularly in the areas of readiness and student achievement. Too many children suffer from learning disabilities that are the result of inadequate prenatal care or from treatable medical conditions that go untreated because their families have little or no health care coverage.

Over the past decade, as health care premiums skyrocketed, many families have had to resort to health care coverage that provides assistance only for catastrophic conditions. Each day, our members work with children who suffer from a wide range of medical conditions that are treatable and/or preventable. Yet too many Americans now rely on hospital emergency wards as primary health care providers. As a result, they have no continuity of care or access to preventive treatments.

Health care costs and health insurance premiums rose sharply over the past decade, while average incomes fell. Employer-provided full family coverage is no longer a given.

As unemployment rose, employers cut back on coverage and expanded cost-sharing. Individual coverage -- outside of a group plan -- became financially unattainable for most Americans.

The costs to families who lack health care coverage are great, but the costs to our society -- in both financial and human resources -- is monumental. A planned program of health care, including prenatal care, inoculations, well-baby care, and regular check-ups is not merely cost effective; it is an investment in our human resources and our nation's long-term economic and national security.

Integrated School-Linked Comprehensive Health Education and Services

Among features of the Health Security Act that we believe should be in any final health care reform plan enacted this year are the provisions to provide $1.5 billion over five years for new integrated school-based clinics run by educators, health officials, and parents, and provisions providing additional resources for planning comprehensive school health programs. Education employees, including teachers and school nurses, already play a key role in identifying children's health care needs and coordinating access to appropriate services. Under these provisions, schools would play an even more significant, and ultimately productive, role in promoting wellness among children. Such programs must be integrated with other health services in the community, and teachers must have input in the design and implementation.

NEA believes a comprehensive program of school health education and services must include school health services, school health education, a safe and hazard-free school environment, integrated school and community health promotion efforts, physical education programs, nutritious food services, school counseling, and wellness programs for faculty and staff. Increasingly, the danger to children's health comes from behaviors, rather than infectious agents. Education, early detection, and a safe and healthful environment in the schools can help promote lifelong wellness habits than will reduce our reliance on expensive treatments down the line.

Approximately 20 percent of all children and adolescents have a diagnosable mental disorder, and only about 6 percent receive some form of mental health care. About 5 percent of children suffer from severe mental disorders, and only three-fourths receive adequate care. Appropriate mental health services must be an element of any final health care reform package.

The longer we ignore the problems of children and families, the longer we delay affirmative steps toward solutions, the worse, the more difficult these issues become. It is imperative that substantive, meaningful health care reform be enacted this session.

Health Care and Education: Competition for Resources

Often unnoted in the health care debate is the direct relationship between the increased costs of health care and the decrease in financial support for public education. Over the past decade, Medicaid, as a share of total state budgets, has outstripped support for higher education. At its present rate, total state and local health care costs -- including direct services and the costs of providing health care coverage of public employees -- may well outstrip spending for elementary and secondary education in the near future.

In 1960, spending for health care was approximately $27 billion, about one-fourth of the $103 billion spent for all education -- public and private, elementary, secondary, and postsecondary. By 1990, health care spending, at $666 billion, was nearly twice as much as education spending, at $365 billion.

State and local governments bear the responsibility for health care services in various ways. As employers, they shoulder the costs of coverage for more than 15 million employees. States share the costs of Medicaid with the federal government, and according the National Governors' Association, Medicaid costs have risen an average of 26 percent each year over the past three years. Many state, county, and municipal governments also provide direct health care services, including support for hospitals, clinics, outreach programs.

As Members of Congress know well, Medicare and Medicaid costs have mushroomed in recent years. Total public expenditures for health care rose by 269 percent between 1980 and 1990. Medicare and Medicaid costs rose from almost 63 percent of public health care expenditures to more than 67 percent. By comparison, public expenditures for child and maternal health declined from 0.08 (eight one-hundredths) percent to 0.07 (seven one-hundredths) percent over the same period.

Unless health care costs are brought under control, health care expenditures are expected to consume the lion's share of public resources. The National Governors' Association projects that Medicaid costs alone will consume 22 percent of total state budgets by 1995. Between 1980 and 1992, Medicare costs rose from 5.4 percent of the total federal budget to 8 percent; other health care spending rose from 3.9 percent of the total federal budget to 6.4 percent.

NEA supports health care reform that will bring costs under control without diminishing quality or rationing services. As a share of Gross Domestic Product (GDP), health care spending has risen much slower among our economic competitors with a large share of public-supported health care. Much of the difference is the cost of administration. Administrative costs for Medicare, for example, are one-seventeenth the cost of private insurance.

Health care reform, without meaningful cost controls, will only exacerbate the strains at the state and local level to address health care needs, education improvement and renewal, and other pressing demands.

We can create a better balance between health care and education. Part of that balance is creating a more efficient system for assuring children's health care needs are met. In the present system, because of benefit cuts, denial of coverage, and the exorbitant cost of individual coverage, children are more likely to be uncovered, and more unlikely to get regular treatment or access to preventive services for necessary, often simple, conditions. Poor health is a prime obstacle to achieving the National Education Goals, especially the first of the goals -- readiness to succeed in school and beyond. Universal coverage to comprehensive health services should be the right of every American.

Dimensions of Comprehensive Reform

National health care reform must provide universal coverage to a comprehensive package of health care treatment and services. And it must bring about significant cost containment.

Of the bills introduced this Congress, only the Health Security Act (H.R. 3600/S. 1757) and the American Health Security Act (H.R. 1200/S. 491) meet the national need for universal coverage and comprehensive treatment and services. Only those two include reasonable provisions for cost containment.

NEA members subscribe to the idea that the greatest efficiencies can be achieved through a tax-supported, single-payer health care network. A single-payer system is the simplest system, offers the most options for individual choice, is best able to bring about cost containment without diminishing the quality of service, and has the greatest potential for economies of scale.

Current public-run health insurance plans spend only one-seventeenth as much on administrative costs as private insurance companies. Moreover, a universal, single-payer plan has the ability to provide true health security for all Americans.

Universal coverage under a comprehensive package of treatment and services -- as envisioned in the Health Security Act and the American Health Security Act -- is the opposite of rationed health care. In fact, the present health care system rations access to health care according to income, preexisting condition, the nature of one's employment, and other factors that have no rational link to need. Moreover, this type of universal coverage to comprehensive treatment and services expands choice for millions of Americans, without significantly limiting the choices now available to those who benefit most under the present system.

Education Employees and Health Care Benefits

Naturally, NEA members, like all Americans, are concerned about the impact of any final on them and their families as health care participants. We believe there should be parity in the treatment of public and private employees and employers in features such as the proposed cap of 7.9 percent cap on employer premiums, and the exemption for existing plans that are analogous to the proposed health care alliances. We believe collective bargaining rights should be preserved to assure consumer protection, quality assurance, and out-of-pocket cost containment.

We are concerned that health care reform not worsen the economic pressures on school districts or education employees. Two circumstances of the public schools require some protection against an undue increase in the individual's share of health care premiums. Public employees include a number of part-time staff, both instructional and non-instructional, and public employees, including teachers, are -- as a rule -- not paid as well as other employees in jobs with comparable levels of responsibility or entrance requirements.

NEA strongly supports the cap on the percentage of wage income employees would have to pay for mandated premiums, and we believe it should not be set any higher than the proposed 3.9 percent.

For many years, NEA has steadfastly opposed the taxation of employee benefits. The Administration plan would exclude from taxation all elements of the guaranteed benefit package. And it would exclude, for 10 years, benefits beyond the basic plan that employees have at the time of adoption. These important provisions must be maintained. Employees have been able to gain these benefits over the years only by trading off wage increases, and they should not be disadvantaged by these changes. Moreover, Section 125 health care plans should be afforded similar protection during this 10-year period.

The Administration's plan proposes the imposition of the Medicare payroll tax on all public employees, a change we have opposed for a number of years. We remain deeply concerned that some state and local employees will be subject to this tax, and yet not be able to accrue sufficient quarters to qualify for Medicare by age 65. All public employees should be deemed qualified for Medicare coverage on reaching the age of 65, provided they have worked 40 quarters, regardless of whether or not such work was subject to the Social Security Medicare tax.

Many of our members presently participate in health care organizations that are comparable to the regional alliances proposed in the Administration's health care plan. In order to minimize disruptions to beneficiaries and build on successful, existing structures, NEA believes that large public entities, such as trusts, voluntary employee benefit associations, and statewide plans, should be able to form separate alliances, if they are acting in the same manner as an alliance and enroll more than 50,000 members, including dependents.

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Finally, given the historical link between collective bargaining and health care benefits, it is essential that the rights and benefits achieved through the collective bargaining process be protected in any health care initiative. We believe that the health care security of millions of families -- and ultimately of our nation -- has been made possible through the balance between employers and employees that is only possible in an environment of collective bargaining.

Our members have a growing recognition that the current system is unsustainable. They have felt the rise in health care costs directly in a number of ways -- through increased out-of-pocket costs, limitations in coverage, and the competition at the state and local level for public expenditures for health versus education.

We recognize the need for greater personal responsibility, both in behaviors that affect health and in terms of being active partners with school boards and state officials in addressing problems in our health care system.

NEA pledges the same type of cooperation with Congress as it works to shape a final health care plan that will address the nation's health care needs, especially as it affects children. Together, I believe we can advance the National Education Goals and achieve the goal of a quality health care system at the same time.

Thank you.

National Education Association
Health Care Policy and Strategy Statement

Adopted by the NEA Board of Directors
February 12, 1993
Amended June 29, 1993

Preface *The NEA supports the adoption of a single-payer health care plan for all residents of the United States, its territories, and the Commonwealth of Puerto Rico. The NEA will support health care reform measures that move the United States closer to this goal and which are consistent with the principles and policies set forth below.*

I. Universal Access

Every resident must be provided with a high level of comprehensive health care coverage.

The components of such coverage are preventive care, in and out-patient hospital care, in and out-patient surgery, doctor visits, chiropractic, diagnostic labs, radiology, prescription drugs, allergy care, organ transplants, mental health, substance abuse, hospice care, dental, vision, long term care, home health care, rehabilitative therapies, and necessary, durable medical equipment.

We oppose the imposition of cost sharing (co-pays), but if there must be some cost sharing, there must be no cost sharing for preventive services.

The coverage must include choice of physician.

Benefits not provided under the comprehensive national plan may be purchased or negotiated through collective bargaining, legislative action, or employer policies. Payment of the employee part of cost sharing may also be negotiated, legislated, or paid by the employer. Health care related benefits must not be taxed.

Health coverage for residents of the United Staes must not be limited to their employment, must be portable, and coverage must not be denied to anyone based on pre-existing conditions, their level of health, or income.

The national plan must prevent risk shifting such as termination or reduction of benefits by employers or providers.

II. Controls

Assured Quality along with meaningful Cost Control is the number one priority of NEA in its support of any national health reform.

The national health reform plan must include both professional and practitioner boards to establish and implement guidelines for medical practices and consumer boards to ensure consumer satisfaction and assess the outcome of medical services.

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All medical services must be included in cost control measures.

Global Budgeting, with guidelines set by a broad based national board with the majority representing consumers, must be included in the reform package, and it must include all of the following:

- Specific, enforceable national expenditure limits
- Specific, enforceable state expenditure limits based on national expenditure guidelines
- Specific, enforceable institutional (hospital) expenditure limits
- Institution capital expenditure limits

Uniform Fee schedules must be established for all medical services. These schedules must include mechanisms to prevent abuses in the volume of procedures and prohibit balance billing and unbundling.

The reform package must include drug cost control measures.

Administrative efficiencies, including a single claims form and community rating, must be included in any reform.

The national plan should include malpractice reform in an effort to control costs which would establish appropriate medical protocols, provide methods to provide malpractice legal costs, and provide for fair compensation to malpractice victims.

Strong enforcement mechanisms must be built into all cost containment measures.

The NEA opposes Managed Competition and/or use of market competition as a vehicle for cost containment.

III. Financing (Long Term Goals and Immediate Steps)

NEA aims for a tax supported, single-payer health care plan in the United States. In the short term, however, NEA may support reforms that utilize taxes and/or employer payments to move us toward greater equity in funding.

Interim steps taken toward the ultimate goal must not cause a cost shift from employers to employees, or create "windfall" savings for employers. Employers must either be made to continue to shoulder their current share of the cost of health care, or they must share their "windfall" with employees or as a tax to pay for the general health care system.

Interim steps taken toward the ultimate goal must also not cause risk shifting by employers or health providers.

Chairman OWENS. Thank you.

Ms. Roberta Doering.

Ms. DOERING. Yes. My name is Roberta Doering, and I serve on my local school board from Agawam, Massachusetts. I am presently serving as vice president of the National School Boards Association, NSBA. I appreciate this opportunity to share with you the views of local education policymakers on health care reform.

The National School Boards Association represents 95,000 local school board members across the country. Over 96 percent of school board members are elected, and they make the key policy and fiscal decisions for the 15,173 school districts nationwide. These districts have an aggregate budget in excess of $225 billion, and they employ and provide a variety of benefits for more than 4.45 million full-time employees.

First let me applaud President Clinton as well as members of this committee for their leadership in tackling the issue of health care reform. It is one of the most difficult issues our society faces. But because millions of Americans either go without health insurance or fear losing it, we must confront this problem.

School board members are particularly concerned about the impact of health care reform on children. We know that when children are not healthy, they simply cannot learn. Unfortunately, over 12 million children under the age of 18 lack health insurance. The result is that every day thousands of children are unable to attend school or they go to school without the proper medical care. The Clinton plan would change this by ensuring that every American child has access to basic health care. Local school board members hope that as a result of these reforms every child will grow up healthy and can take full advantage of educational opportunities.

Today I will discuss five issues of great significance to children and to schools: A, the need for adequate children's mental health benefits; B, the legislation's discriminatory treatment of illegal immigrant children; C, the need for expanded coverage for students with disabilities; D, the legislation's unfair treatment of public employers such as school districts; and, E, the importance of the health education and school health centers provisions of the bill.

Mental health care for children: In part because of lack of health insurance, mental health services for children are now woefully inadequate. About 12 to 15 percent of children suffer from some type of emotional or mental disorder. Sadly, only about 5 percent of these children receive the treatment they need.

NSBA strongly supports the Clintons' plan's mental health care provision and believes that these services for children should be expanded. Adequate mental health services help children reach their full academic potential. Moreover, mental health care can help youngsters put substance abuse or delinquency problems behind them and even avoid these problems entirely. Finally, mental health care can help students avoid a leading cause of death among their age group, teenage suicide.

The legislation's basic benefit package provides for comprehensive and flexible mental health coverage that will help tens of thousands of children lead healthy, productive lives. NSBA urges the committee to retain these provisions and to reduce the limitations on these services.

B, the legislation penalizes innocent children through the discriminatory treatment of illegal immigrant students. NSBA believes that all children should receive the health care they need. Unfortunately, with the exception of emergency medical care, the Health Security Act does not cover illegal immigrant children. As a result, many children may not receive the health care they need.

The Clinton plan should not penalize children if they and their parents are illegal immigrants. Policymakers need to remember that these immigrant children have followed their parents to this country. The children have done nothing wrong; they have merely obeyed their parents' instructions. We should not penalize children for the action of their parents.

NSBA believes that all children, regardless of their citizenship status, should be covered by the national health care reform. In this way, all students will receive the health care they need and will arrive in school ready to learn.

C, expanding Medicaid coverage for students with disabilities. Under current law, Medicaid ensures that many low-income children with disabilities receive a broad range of medical care such as psychological services and nursing services. This Medicaid coverage is critical in providing these children with the health services they need. Schools provide many of these same health services as a result of the requirements of the Individuals with Disabilities Education Act, IDEA, and in many States schools can receive Medicaid reimbursement for providing these services. Thus, Medicaid reimbursement for these services helps our school systems devote more resources to providing core educational services to all of our children.

Unfortunately, it is not clear that the President's health security plan will continue to provide the full range of services currently available for these children. NSBA hopes the committee ensures that no reduction in health coverage for children with disabilities will result from an enactment of the plan. In fact, Medicaid coverage should be expanded both to help children with disabilities and to ensure that more schools can receive reimbursement for providing these services that are largely medical in nature.

D, ending the disparate treatment of public employers would strengthen the school system. NSBA has several concerns about the legislation's impact on the quality of public education. The legislation imposes a cap of 7.9 percent of payroll on private employers. However, such protection is not available to public employers and thus not available to school districts.

The lack of a cap on health care expenses is a problem because many school districts would be required to pay substantially more to provide health insurance for their employees. Additional financial burdens on school districts include the payment of 80 percent of premiums for every employee, including family coverage, the cost of supplying benefits to part-time employees and richer health benefits to employees who have bargained for lesser health benefits in favor of other compensation. And local taxpayers, so wary of approving revenue-raising measures, might balk at financing these extra costs.

NSBA hopes that members of the committee will try to end the disparate treatment of private and public employers. By asking local school districts to shoulder these extra costs, public schools will have more difficulty in providing the world class education that is so important to our children's future.

E, health education and school-related health centers. The President's legislation contains provisions specifically targeted to help schools' efforts to improve the health of students. The Health Security Act establishes a $50 million per year program of grants to States and localities to support health education programs addressing local priorities. This program is a critically important first step in providing our youth with the information they need to lead healthy lives.

NSBA has been extremely active in fostering comprehensive school health programs in our schools, and we have done a great deal of training across the country of local school board members in how to establish a comprehensive program and how to work with their local communities and establish the local needs.

The Clinton plan also provides $1.5 billion in grants for school health centers to improve the health of our Nation's youth and allows these centers to receive insurance reimbursement. These provisions are a highly cost-effective way to help our Nation's youth gain access to the health care they need.

The health education programs and health centers can help ensure that American children come to school ready to learn and leave school in good health, and we urge the committee to support these components of the legislation.

NSBA applauds the President for introducing a plan that will result in improved health care for millions of Americans. In your committee's review of this legislation, NSBA urges you to ensure that health needs of children and youth receive additional protection. In this way, all of our children can go to school ready to learn and leave school healthy, well educated, and ready for the challenges of tomorrow.

Thank you for the opportunity to present the views of local school boards. Please feel free to contact NSBA if we can provide you with further information on these issues.

I would like to close with a quote from a famous educator, Horace Mann. "In the great work of education, our physical condition, if not the first step in point of importance, is the first in order of time. On the broad and firm foundation of health alone can the loftiest and most enduring structures of the intellect be reared."

Thank you very much.

[The prepared statement of Ms. Doering follows:]

Roberta G. Doering
School Board Member
Agawam, Massachusetts
and
Vice-President
National School Boards Association

TABLE OF CONTENTS

I. INTRODUCTION .... Page 1
II. SCHOOL BOARD RECOMMENDATIONS .... Page 2
III. CONGRESSIONAL ROLE .... Page 7

I. INTRODUCTION

I am Roberta G. Doering, a local school board member from Agawam, Massachusetts and Vice-President of the National School Boards Association (NSBA). I very much appreciate this opportunity to share with you the views of local education policy-makers on health-care reform.

The National School Boards Association represents the 95,000 local school board members across the country. Over 96% of school board members are elected, and they make the key policy and fiscal decisions for the 15,173 school districts nationwide. These districts have an aggregate budget in excess of $225 billion and they employ and provide a variety of benefits for more than 4.5 million full-time employees.

II. SCHOOL BOARD RECOMMENDATIONS

First, let me applaud President Clinton as well as members of this Committee for their leadership in tackling the issue of health-care reform. It is one of the most difficult issues our society faces. But because millions of Americans either go without health insurance or fear losing it, we must confront this problem.

School board members are particularly concerned about the impact of health-care reform on children. We know that when children are not healthy they simply cannot learn. Unfortunately, over 12 million children under age 18 lack health insurance. The result is that every day thousands of children are unable to attend school or they go to school without proper medical care.

The Clinton plan would change this by insuring that every American child has access to basic health-care. Local school board members hope that as a result of these reforms every child will grow up healthy and can take full advantage of his or her educational opportunities.

Today I will discuss five issues of great significance to children and to schools:

A) The need for adequate children's mental health benefits;

B) The legislation's discriminatory treatment of illegal immigrant children;

C) The need for expanded coverage for students with disabilities;

D) The legislation's unfair treatment of public employers such as school districts; and

E) The importance of the health education and school health center provisions of the bill.

……

A. Mental Health Care for Children

In part, because of a lack of health insurance, mental health services for children are now woefully inadequate. About 12-15% of children suffer from some type of emotional or mental problem. Sadly, only about 5% of these children in the general population receive the treatment they need.

NSBA strongly supports the Clinton plan's mental health care provisions and believes that these services for children should be expanded. Adequate mental health services help children reach their full academic potential. Moreover, mental health care can help youngsters put substance abuse or delinquency problems behind them or even avoid these problems entirely. Finally, mental health care can help students avoid a leading cause of death among their age group -- teenage suicide.

The legislation's basic benefit package provides for comprehensive and flexible mental health coverage that will help tens of thousands of children lead healthy productive lives. In addition, the legislation contains Medicaid provisions that will provide important assistance to children with serious emotional problems. NSBA urges the Committee to retain these provisions and to reduce the limitations on these services.

B. Penalizing Innocent Children -- The Legislation's Discriminatory Treatment of Illegal Immigrant Students

NSBA believes that all children should receive the health-care they need. Unfortunately, with the exception of emergency medical care, the Health Security Act does not cover illegal immigrant children. As a result, many children may not receive the health-care they need.

NSBA should not penalize children if they and their parents are illegal immigrants. Policy-makers need to remember that these immigrant children have followed their parents to this country. The children have done nothing wrong; they have merely obeyed their parents' instructions. We should not penalize children for the actions of their parents.

This exclusion also means that school health centers in most cases will not be able to receive insurance reimbursement for providing health services to these students. Health centers can provide services to students who are citizens. But we are creating a situation where some centers may turn away children who are illegal immigrants. School administrators could be left with a difficult dilemma. They could either refuse to give these students health-care or they would have to divert scarce educational dollars to provide all students with needed medical services. We should not force our schools into making such a choice nor force our children to accept such a fate.

NSBA believes that all children, regardless of their citizenship status, should be covered by the national health-care reform. In this way, all students would receive the health-care they need and will arrive in school ready-to-learn.

This issue serves as a reminder of a larger problem -- federal government's failure to contribute adequately to the costs of educating immigrant students. Local school districts are shouldering the lion's share of the costs of providing expensive services to immigrant children. But school districts are unable to bear all these costs on their own. Unless programs such as the Emergency Immigrant Education Act receive a major infusion of new funds, we risk fueling a backlash against immigrant children and invite the deterioration of educational programming for all children living in areas impacted by immigration.

C. Expanding Medicaid Coverage for Students with Disabilities Would Ensure These Children Reach Their Full Potential

Under current law, Medicaid insures that many low income children with disabilities receive a broad range of medical care such as psychological services or nursing services. This Medicaid coverage is critical in providing these children with the health services they need.

Schools provide many of these same health services as a result of the requirements of the Individuals with Disabilities Education Act (IDEA). And in many states schools can receive Medicaid reimbursement for providing these services. Thus Medicaid reimbursement for these services helps our school systems devote more resources to providing core educational services to all our children.

Unfortunately, it is not clear that the President's Health Security Plan will continue to provide the full range of services currently available for these children. NSBA hopes the Committee makes sure that no reductions in health coverage for children with disabilities will result from enactment of the plan. In fact, Medicaid coverage should be expanded both to help children with disabilities and to ensure that more schools can receive reimbursement for providing these services that are largely medical in nature.

As members of the Committee know, there are many interconnections between health-care reform and IDEA, and both have a major impact on school district finances. As the Committee considers health-care reform and the reauthorization of IDEA, NSBA believes you should consider mechanisms for providing school districts with additional resources for implementing IDEA.

C. Ending the Disparate Treatment of Public Employers Would Strengthen the Public School System

At field hearings, NSBA has described our concerns about certain provisions of the legislation which could have a detrimental impact on school district finances. Today, I would just like to reiterate briefly our major points.

The legislation recognizes the financial hardship that health-care reform could have on private employers by capping their maximum health-care costs at 7.9% of payroll. However, such protection is not available to public employers and thus not available to school districts.

The lack of a cap on health-care expenses is a problem because many school districts would be required to pay substantially more to provide health insurance for their employees. Additional financial burdens on school districts include the payment of 80% of premiums for every employee including family coverage, the cost of supplying benefits to part-time employees, and richer health benefits to employees who have bargained for lesser health benefits in favor of other compensation. And local taxpayers, so wary of approving revenue-raising measures, might balk at financing these extra costs.

NSBA also hopes that the legislation's prohibition on governments, including school districts, from creating their own health alliances can be lifted. Under current law this self insurance is permitted and allows many school districts to offer school personnel more comprehensive benefits at a lower cost.

NSBA hopes that members of the Committee will try to end the disparate treatment of private and public employers. By asking local school districts to shoulder these extra costs, public schools will have more difficulty in providing the world class education that is so important to our children's future.

E. Health Education and School Related Health Centers

The President's legislation also contains provisions specifically targeted to assist schools' efforts to improve the health of students. The Health Security Act establishes a $50 million per year program of grants to states and localities to support health education programs addressing local priorities. This program is a critically important first step in providing our youth with the information they need to lead healthy lives.

The Clinton plan also provides for $1.5 billion in grants for school health centers to improve the health of our nation's youth, and allows these centers to receive insurance reimbursement. These provisions are a highly cost-effective way to help our nation's youth gain access to the health-care they need.

School board members also strongly believe in the importance of local education decision-making. This can maximize community support for these programs and insure that the highest priority local needs are met. NSBA urges the Committee to give local policy-makers the flexibility to implement the health education programs and health centers in a manner consistent with local priorities. In this way, these valuable programs can help ensure that American children come to school ready-to-learn and leave school in good health.

III. CONGRESSIONAL ROLE

NSBA applauds the President for introducing a plan that will result in improved health-care for millions of Americans. In your Committee's review of this legislation, NSBA urges you to ensure that the health needs of children and youth receive additional protection. In this way, all our children can go to school ready-to-learn and leave school healthy, well educated, and ready for the challenges of tomorrow.

Thank you for the opportunity to present the views of local school boards. Please feel free to contact NSBA if we can provide you with further information on these or other issues.

Chairman OWENS. Thank you.

Dr. Witucki.

Mr. WITUCKI. Good morning.

My name is Michael Witucki, and I am the associate superintendent of the Wayne County, Michigan, Regional Educational Service Agency, which provides direct educational services to the schools in Detroit and its neighboring suburbs. In all, Wayne County RESA provides services to 34 school districts and over 360,000 students, 35,000 of whom are special education students.

In the Goals 2000 legislation, several national educational goals were adopted. One of these was that by the year 2000 all children in America will start school ready to learn. If we are to meet this goal, then we must concentrate and coordinate the efforts of all of our social agencies towards this goal. Most studies indicate that the two factors most significant in determining a child's success in school are parental involvement and the socioeconomic status of the child.

In a recent study conducted by Wayne State University in Detroit on the status of Detroit area youth, the following alarming statistics were underscored: 46 percent of all children in Detroit live in poverty; 65 percent of all special education children in Detroit are Medicaid eligible; single females with children account for 19 percent of all households in Detroit making it the typical household in Detroit; 55 percent of single females with children live in poverty; and, 25 percent of all newborns in Detroit are born to unwed teens.

Clearly, if by the year 2000 all children will start school ready to learn and if parental involvement and socioeconomic status are the chief indicators of the likelihood of a child's success in school, then the task of all of the agencies who are responsible for the health, well-being, and education of our Nation's young people is a critical one.

The time has come for all of our social service agencies to work together to create a school-centered plan for the collaborative delivery of services. The one institution that continues to be the heart of the local community is the local public school. One model of such a cooperative educational effort for special education students has been developed in Michigan.

As associate superintendent, one of my duties over the past 18 months has been to serve as the project officer for a large collaborative State agency initiative to implement a Medicaid program for school-based health services in Michigan. This initiative included four State agencies and the sixth largest RESA in Michigan. The school-based health services Medicaid reimbursement program is being coordinated by the Wayne County RESA on behalf of the 34 school district located in Wayne County.

School-based health services is a Medicaid program which allows a regional educational service agency to obtain reimbursement for certain services provided to special education students who are Medicaid eligible. This program is consistent with the mandates and policies of both the Medicaid program and the Michigan Department of Education.

Currently, this program enables enrolled providers to bill for the following health-related services: speech and language, occupational therapy, physical therapy, nursing, psychological and social work services, developmental testing, IDEA assessments, and transportation.

My main purpose today is to share my perspective on the Michigan Medicaid program for schools and to emphasize those Federal modifications which would greatly simplify the implementation process.

First of all, I want to stress that Medicaid is an important new revenue source for schools. It is a long overdue source of revenue. Twenty years ago, many of the children we now serve in special education programs would have been served in specialized State institutions. These specialized State facilities were funded in large part by Federal dollars, including Medicaid dollars. Over the past two decades, these large State facilities have either been downsized or closed, and their residents have been transferred to the least restrictive environment. In many cases, the least restrictive environment was inclusion in the public school system.

Unfortunately, the revenue streams that were available to support children in institutional settings were not equally available in community-based settings. The introduction of Medicaid as a revenue source of public schools fulfills a long outstanding promise from the Federal and State governments that existing revenue sources would follow the child as the deinstitutionalization initiative unfolded and community-based programs evolved to respond to the influx of the more severely involved students.

Although Medicaid funds are now available in the public school system, the process of accessing these funds is still in its infancy. I believe this process can be simplified with your assistance and support. Congress can provide specific assistance to other States and other districts that are now following in the footsteps of the Michigan model reimbursement program. This assistance includes: one, an exemption from the Medicaid managed care initiative; two, legislative relief in lifting confidentiality restrictions which impair our ability to collaborate with the State Medicaid agency in identifying Medicaid eligible students; three, to gain State support for the creation of a flexible Medicaid program, it has been necessary for the schools to agree to share with the State some of the new revenues; guidelines setting forth the permissible ranges of the sharing of revenues are desirable; four, relief from current HCFA regulations which specify physician prescription or referral for speech therapy, occupational therapy, and physical therapy; and, five, release from recent HCFA regulations which will tend to prevent small school districts from participating in the Medicaid program.

Your action on these five areas of program clarification will be of considerable assistance to school districts throughout the Nation as they begin to develop their Medicaid programs for school-based health services.

We are very proud of the program that we have developed in the State of Michigan. Its potential for providing increased school-based health services to our economically deprived special education students is tremendous. We feel that we have developed a model program and welcome sharing it across the Nation.

If you should have any questions, I would be happy to respond to them.

[The prepared statement of Mr. Witucki follows:]

STATEMENT OF MICHAEL WITUCKI, ED.D., ASSOCIATE SUPERINTENDENT, WAYNE COUNTY REGIONAL EDUCATION SERVICE AGENCY, WAYNE COUNTY, MICHIGAN

Good morning.

My name is Michael Witucki and I am the Associate Superintendent of the Wayne County (Michigan) Regional Educational Service Agency which provides direct educational services to the schools in Detroit and its neighboring suburbs. In all, Wayne County RESA provides services to 34 school districts and over 360,000 students, 35,000 of whom are special education students.

In the Goals 2000 legislation enacted by Congress several national educational goals were adopted. One of these was that "By the year 2000 all children in America will start school ready to learn." If we are to meet this goal, which when met will be an effective way of improving public education, then we must concentrate and coordinate the efforts of all of our social agencies towards this goal. Most studies indicate that the two factors most significant in determining a child's success in school are parental involvement and the socioeconomic status of the child. (In general, economically poorer children fare far more poorly in school.)

In a recent study conducted by Wayne State University on the status of Detroit area youth, the following alarming statistics were underscored:

- Forty six percent of all children in Detroit live in poverty (65 percent of all Special Education children in Detroit are Medicaid eligible);
- Single females with children account for 19 percent of all households in Detroit (which makes it the "typical" family type in Detroit;
- Fifty five percent of single females with children live in poverty;
- Twenty five percent of all newborns in Detroit are born to unwed teens.
- In 1990, the average amount of money spent to educate one child in the Public School System in Michigan was $3,600 a year. The average spent to house one prisoner in a State prison was $36,000 per year. The common denominator among the State's prisoners was that they were school dropouts.

Clearly, if by the year 2000 all children will start school ready to learn and if parental involvement and socioeconomic status are the chief indicators of the likelihood of a child's success in school, then the task of all of the agencies which are responsible for the health, well-being, and education of our Nation's young people is a critical one.

The time has come for all of our social service agencies to work together to create a school-centered plan for the collaborative delivery of services. The one institution that continues to be the heart of the local community is the local public school. While decrying the failure of public education elsewhere, invariably, citizens of local communities universally support and approve of their local school.

One model of such a cooperative educational effort for special education students has been developed in Michigan.

As Associate Superintendent, one of my duties over the past 18 months has been to serve as the Project Officer for a large collaborative State agency and RESA initiative to implement a Medicaid program for school-based health services in Michigan. This initiative included four State agencies and the sixth largest RESAs in Michigan.

The School-Based Health Services Medicaid Reimbursement Program is being coordinated by the Wayne County Regional Education Service Agency on behalf of the 34 school districts located in Wayne County. School-Based Health Services (SBHS) is a Medicaid program which allows a Regional Educational Service Agency to obtain reimbursement for certain services provided to Special Education students who are Medicaid eligible. This program is consistent with the mandates and policies of both the Medicaid Program and the Michigan Department of Education.

The Michigan Medical Services Administration has issued a Medicaid Bulletin which describes the covered health-related services provided to students and youth eligible under provisions of the Individuals With Disabilities Act (IDEA) of 1990. Medicaid reimbursement addresses the health/medical service needs of Medicaid eligible children and youth receiving Special Education services and provides for funding. The Social Security Act, as amended in 1988 by the Medicaid Catastrophic Coverage Act, specifically provides for medical assistance to cover services which are "included in the Child's Individual Education Plan (IEP) established pursuant to Part B of the IDEA."

Currently, the SBHS Program enables enrolled providers to bill for the following health-related services:

- Speech and Language, including Audiology;
- Occupational Therapy;
- Physical Therapy;
- Nursing;
- Psychological and Social Work services;
- Developmental testing;
- IDEA assessments; and
- Transportation.

My main priority today is to share my perspective on the Michigan Medicaid program for schools and to emphasize desirable Federal modifications which would greatly simplify the implementation process.

First of all, I want to stress that Medicaid is an important new revenue source for schools. I believe it is a long overdue source of revenue.

Twenty years ago, many of the children we now serve in Special Education program would have been served in specialized State institutions. These specialized State facilities were funded in large part by Federal dollars, including Medicaid dollars. Over the past two decades, these large State facilities have either been downsized or closed, and their residents have been transferred to the "least restrictive environment." In many cases, the "least restrictive environment" was inclusion in the public school system.

Unfortunately, the revenue streams that were available to support children in institutional settings were not equally available in community-based settings. Accordingly, the transfer of children from institutional programs to public school system programs created enormous financial pressures for the public school system.

The introduction of Medicaid as a revenue source of public schools fulfills a long outstanding promise from the Federal and State governments that existing revenue sources would follow the child as the "deinstitutionalization" initiative unfolded and community-based programs evolved to respond to the influx of the more severely involved students.

Although Medicaid funds are now available to the public school system, the process of accessing these funds is still in its infancy. I believe this process can be simplified with your assistance and support.

Congress can provide specific assistance to other States other school districts that are now following in the footsteps of the Michigan "model."

This assistance includes:

1. *An exemption from the Medicaid "managed care initiative."*

In Michigan there was considerable pressure to fold school-based health services into the State's "managed care initiative." This would have resulted in two separate health care programs for students. Poor children who were Medicaid eligible would have been bused to a managed care provider for their Speech or Occupational Therapy while non-Medicaid students would receive these same services from the school.

Conflicts would also quickly arise between the Managed Care Provider's perception of a child's health care needs and that of the school district as specified in the IEP.

This issue can be resolved by granting school-based health services an exemption from the "managed care initiative."

2. *Legislative relief in lifting "confidentiality restrictions" which impair our ability to collaborate with the State Medicaid Agency in identifying Medicaid eligible students.*

Medicaid regulations allow the State Medicaid Agency to assist the schools in identifying Medicaid eligible students. Education regulations, however, deter school districts from sharing student enrollment information with the Medicaid Agency for the purpose of identifying Medicaid eligible students.

3. *To gain State support for the creation of a flexible Medicaid program, it has been necessary for the schools to agree to share with the State some of the new revenues. Guidelines regarding the permissible ranges for the sharing of revenues are desirable.*

I want to stress that I believe it is essential that the schools and the State both share the Medicaid revenues because both jointly fund school-based health services. I believe that legislation should be enacted which limit Medicaid recoveries for States to the proportionate share of costs borne by the State in funding school-based health services.

4. *Relief from current HCFA regulations which specify physician prescription or referral for Speech Therapy, Occupational Therapy, and Physical Therapy.*

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School-based Speech, Occupational and Physical Therapy have historically been prescribed by licensed therapists acting within their area of specialization.

In accessing Medicaid, it is now necessary to secure a physician's prescription or referral for these services. We believe this is wasteful, expensive and unnecessary. The adoption of Education's standards and processes for the prescription of Occupational, Physical and Speech Therapy would go far to simplify the Medicaid program for participating schools.

5. *Relief from recent HCFA regulations which will tend to prevent small school districts from participating in the Medicaid Program.*

Recently HCFA issued regulations which allowed schools to claim Medicaid reimbursements only if at least one therapist in a specialization area was an employee of the District. As an example, Wayne RESA could bill Medicaid for Speech Therapy if it hired Speech Therapists or used a combination of in-house and contracted Speech Therapists. Under the new HCFA regulations we are prevented from claiming reimbursement for Speech Therapy if we use contracted staff entirely to provide the Speech Therapy service.

Clearly, a large RESA can structure its program to conform with this new HCFA requirement. By contrast a small district which contracts with a part-time speech therapist will lose the ability to seek Medicaid reimbursement.

Your action on these five areas of program clarification will be of considerable assistance to school districts throughout the Nation as they begin to develop their Medicaid programs for school-based health services.

We are very proud of the program that we have developed in the State of Michigan. Its potential for providing increased school-based health services to our economically deprived Special Education students is tremendous. We feel that we have developed a model program and welcome sharing it across the Nation.

I will be happy to respond to any questions you might have.

Chairman OWENS. Thank you.

Mr. Witucki, do you feel that the health care reform program is likely to eclipse what you have done?

Mr. WITUCKI. We hope that it does not, and I would like to reiterate Roberta's comments that we think this particular program could very well be the cornerstone for school-based services being provided through the Clinton plan. We would hope that this kind of funding or access to this kind of funding, particularly for our special education youngsters, would be continued.

Chairman OWENS. You would like to see the $1.5 billion used to set up replicates of what you are doing in school-based centers?

Mr. WITUCKI. I think it is an excellent model for folks to follow, correct.

Chairman OWENS. Ms. Doering, do you foresee the costs for school boards going up dramatically under health care reform?

Ms. DOERING. We hope not. That is why we have laid out some of our concerns, so that the additional costs won't raise the budgets that we are dealing with. You as well as everyone else in this room know the problems that school boards have in getting their budgets passed within their local communities. We have cited some things that we would hope would help us in that effort.

Chairman OWENS. Would you say that mental health, which you are greatly concerned about, is not clear in the President's package?

Ms. DOERING. The President's package doesn't cover all the children that need the services. It doesn't allow them to access that service. There is a section of the Health Security Act that stresses mental health, which would address the emotional problems that children that are learning barriers. We hope that this section remains in the Act and provides additional money.

Chairman OWENS. You believe that if the government plan continues to insist it is not going to cover the adults in illegal immigrant families, it should at least cover children?

Ms. DOERING. We feel that children shouldn't be penalized because they are there because of their parents, and if they present themselves to the school, the school should be able to take care of those children. I think you cited earlier that many of those children come to school with all kinds of problems and all kinds of health-related problems, and we would like to be able to take care of them.

Now some schools are doing that already, but in order to provide those services, they are taking money out of their educational budget. So we would like some coverage for those illegal immigrant children.

Chairman OWENS. You are providing some health care services now, right?

Ms. DOERING. Yes. I think it would be very difficult for a principal in a school to deny a student a need if it was there.

Chairman OWENS. Ms. Monahan, thanks for your endorsement of the single payer system. I certainly am a supporter of the single payer and glad to see NEA is clearly and forcefully in line with that.

The 7.9 percent cap, can you explain a little bit more how that hurts schools in particular?

Ms. MONAHAN. Well, as we understand it, there is a cap for 7.9 percent for the private sector but not for the public sector. There is not the same parity between the public and private sector employers. If the cost for providing benefits for the employees of a public school system exceeds a certain amount, the school would still have to pick up the tab. If it were in the private sector, the government would say that the private sector employer would only have to pay so much and then the government would help.

When it comes to the public sector, it is not the same. The cap is going to be phased in over a longer period of time before you achieve it. The costs could be significantly higher in a school district and yet the government would not step in to help.

Chairman OWENS. Since the first introduction of the President's plan, that has been a problem for public employee unions. Have there been any negotiations to date? Any movement on that issue?

Ms. MONAHAN. I am going to check with our people. They are still discussing it, but we wanted to go on record here to place before you the concerns while we continue to negotiate it before a final plan is adopted by Congress.

Chairman OWENS. Many school systems—I know New York City—do not provide health benefits for part-time employees and substitute teachers. Is that likely to have a great impact on the financing of schools if they are factored into the mandate for coverage for everybody, the financing of the schools?

Ms. DOERING. Yes, it could.

Ms. MONAHAN. Yes, and I believe in our written testimony you will find some references to the providing of health care coverage for the part-time and those that are not now provided. That will cause a concern as this cap enters into it at the same time.

Chairman OWENS. Mr. Lubin, you drove right to the center of the matter, whereas in the testimony of the Surgeon General and Dr. Payzant there was kind of a vagueness about where we were going with this process. You think school-based clinics ultimately should be part of the health alliances and providers. Do you want to expand on this opinion?

Mr. LUBIN. We believe that States will have a minimum of one health alliance and some States will have more than one health alliance, and we think that it should be part of their responsibility to provide the school-based or the off-site clinics. We don't believe it should be done differently in every single school district.

We often have children who go to schools in two different districts. A brother and his sister might go to schools in two different school districts within certain parameters. If there is one program that is developed by that area alliance, then it would be a better system for the students, and it would take some of the local issues and handle them on a larger basis.

I was listening this morning, and I would hope that the concern that some Members of Congress have about certain issues within the programs can be dealt with on a larger basis than an individual school district.

We have to remember that the alliances, according to the Clinton program, are going to be driven by the consumers. The alliances are not going to be controlled by the insurance companies. We would like to see a more stable system of benefits available to students, as many of our low-income students move from one district to another. There shouldn't be greatly different health programs available to them. There should be some similarity and some continuation which can be controlled by the State.

Ms. DOERING. Could I make a comment on that? NSBA supports the health clinics or school-based clinics, but not every school would have a clinic based in their school, and we feel that that is a local decision.

Where I come from, we have a number of urban communities that hire nurse practitioners or school physicians so that many of those duties are taken care of.

Many school districts also have lists of agencies that they can refer their students to, and don't perceive a need. However, I think there are some schools—especially in larger urban schools, where there is a definite need to take care of the health problems.

A neighboring community where I live, has a school-based clinic treating all kinds of things: students with headaches, sore throats, and earaches. Some of those students would never have any medical care if that clinic was not based in the school. This district has found that the attendance of those students is greater than ever before.

But I think it depends. I think you have to look at your local communities and let them decide, but we support the concept.

Chairman OWENS. Medicaid-based centers or Medicaid-funded centers, are based on the assumption that there is enough of a concentration of Medicaid eligible students in a given place.

Mr. WITUCKI. That is correct. In order to make it economically feasible at this time, we can really only focus in on those areas with high concentration of Medicaid eligible youngsters.

We do see things happening in the future, however, the development of statewide computer-based programs which would allow further exportation of those services and accessibility of those Medicaid funds to the more rural areas, and that is precisely what is happening now in the State of Michigan.

When we first started the program, we concentrated on five or six large metropolitan areas. Since the program is now up and running, several of the outlying areas in the State are now applying for the program and beginning to get some funds.

Chairman OWENS. Are you saying that others wish to share in your revenues?

Mr. WITUCKI. Yes, that is part of the problem.

Chairman OWENS. The revenues are so great, you have a surplus.

Mr. WITUCKI. That is correct. Perhaps the most difficult thing to overcome at the State level is the cooperation and collaboration between State agencies. There are some tremendous turf issues, as I am sure you are very, very aware, in State agencies.

So it is very difficult for Education, for example, to go to the Department of Social Services, the Department of Mental Health and get them to agree to share and cooperate in these kinds of programs. There has to be some bargaining for resources. It is unfortunate, but it is a fact.

Chairman OWENS. So within the health alliances, one of your clinics would be a provider?

Mr. WITUCKI. That is correct. Wayne County RESA has been named as a Medicaid provider, and when we provide special education services to the medically fragile, we are now able to bill for a percentage of those services to Medicaid. However, in order to get the State agencies to agree, we have had to share the revenues.

Fortunately, we have been able to convince our governor and our State legislature to take that money and turn it into an early childhood program. The benefit we are seeing from these revenues and sharing with the State are better educational programs for preschool kids and some good health programs for preschool kids. We have been able to prevail upon them to not just take that money and dump it into the general fund. We have used a little political pressure to see that they use those funds for a new program for kids who are eligible for Medicaid.

Chairman OWENS. Mr. Lubin, you mentioned existing school-based clinics should be evaluated and some of them may be retained. Would they operate in the same way? Would they become providers and the alliance would be paying them for service?

Mr. LUBIN. I imagine most of them could become supported by an alliance and be evaluated on the basis of what services they were offering and continue to offer. At this point, clinics exist in the North and the eastern coast. There are some in California, and New Mexico has a large number of them, but there are very few around the country.

Chairman OWENS. Thank you very much. As you can see from the presence of a number of our colleagues here before, this is a concern which is on the minds of quite a number of congressmen. School-based health care is an area of great uncertainty and vagueness in the total benefits package. Since it is still not as clear as other parts of the package, your testimony has been very valuable, and we certainly appreciate your coming.

Chairman OWENS. Our third and final panel: Dr. Paula Duncan, director of the Vermont Department of Maternal and Child Health, American Academy of Pediatrics; Dr. Patrick Cooper, the executive director of the National School Health Education Coalition; and Ms. Brenda Welburn, the executive director of the National Association of State Boards of Education.

We have copies of your written statements which will be entered in their entirety within the record.

We will begin with Dr. Duncan.

STATEMENTS OF PAULA DUNCAN, M.D., DIRECTOR, VERMONT DEPARTMENT OF MATERNAL AND CHILD HEALTH, AMERICAN ACADEMY OF PEDIATRICS, WASHINGTON, DC; PATRICK COOPER, EXECUTIVE DIRECTOR, NATIONAL SCHOOL HEALTH EDUCATION COALITION, WASHINGTON, DC; AND BRENDA WELBURN, EXECUTIVE DIRECTOR, NATIONAL ASSOCIATION OF STATE BOARDS OF EDUCATION, ALEXANDRIA, VIRGINIA

Dr. DUNCAN. Mr. Chairman, I am Dr. Paula Duncan, director of Vermont Maternal Child Health in Burlington, Vermont, the Public Health Department. I am here today representing the American Academy of Pediatrics, as a member of its Committee on School Health. The Academy is an organization of 47,000 pediatricians dedicated to the health, safety, and well-being of infants, children, adolescents, and young adults.

The Academy commends your efforts to explore the linkages between health care reform and improved educational outcomes. I am especially pleased to be able to testify before the Education and Labor Committee because I have spent a great deal of my professional career working with and in schools to make children healthier so they will be better ready to learn.

Six years ago, I moved from a private pediatric practice setting to a full-time school position as a health education teacher and health services coordinator. That experience really helped me to understand firsthand how complex children's needs are, the challenges that teachers, school nurses, and other school staff are facing on a daily basis, and how closely children's health and education needs are linked.

Health education and social services share the common goal of improving well-being of our Nation's children. We must all take that shared commitment with us as we develop policies that affect their future. My testimony will focus on three issues: Why a comprehensive school health program is important for our children's future; the impact of health care reform on schools; and, the importance of the integration of health, education, and social services within the context of a comprehensive school health program.

The Academy would like to commend the President for including a comprehensive school program within the Health Security Act. The legislation establishes a national framework within which States can create a comprehensive school health education program that improves the health and well-being of students grades kindergarten to 12 by addressing locally relevant health priorities and reducing behavior patterns associated with preventable mortality and morbidity.

Schools are a microcosm of the society. Whatever social, health, or political issues are present in society will manifest themselves in the school. School health has been historically underemphasized and neglected as a potential way to reach and impact a large number of children. Many of these children otherwise might have difficulty gaining access to health education or other related services.

Traditional definitions of school health deal with three areas: health services, health education, and a healthy school environment. While these are important, it is necessary now to view school health as a broader range of school-based and community-based activities. These activities coordinate education, social, and health care institutions to assist families and children in preventing disease, promoting and protecting health, and minimizing the complications of health problems of schoolage children.

The American Academy of Pediatrics has developed seven goals for school health programs. They are to assure access to primary health care and provide a system of dealing with crisis medical situations, mandated health screenings and immunization monitoring, systems for identification and solution of students' health problems and educational problems, comprehensive and appropriate health education, a healthy and safe school environment, and a system of evaluation of the effectiveness of the school health program.

Comprehensive school health has the potential to maximize health and educational outcomes for children and youth by attempting to focus the efforts of families, community institutions, and the systems that impact them. For example, the primary goal of health education, one component of the comprehensive school health program, is to provide students with the knowledge, skills, and behavior to choose a health enhancing lifestyle.

Positive reinforcement for healthy behavior based on acquired knowledge, skills, and values is a powerful method to improve health outcomes in children and youth. The school environment is rich with opportunities to implement such a model.

In addition to ensuring that all children have access to comprehensive school health education programs, we must ensure that our children have access to high quality health care services as well. With comprehensive health care reform, which includes this health education program, the health status of all children will improve. With that improvement, children will be much more likely to come to school ready to learn every day of their school experience.

The Academy supports the President's health care reform initiative and views the Health Security Act as the best vehicle proposed to date to achieve the kind of health care reform that children need. Congress must move forward on comprehensive health care reform, reform that includes integrating services, or our children's future and security indeed really will be at risk.

I would like to explain why the Academy believes health care reform is necessary. Children desperately need access to comprehensive health services. The importance of addressing child health issues must not be viewed simply as an act of compassion. Providing children and adolescents access to quality health care with an emphasis on prevention is the single most important economic decision that will be made in the health care reform debate. Health care reform should not merely finance existing systems of health care that focus on treatment rather than prevention.

Mr. Chairman, as you and other Members of Congress consider the health care reform legislation, you face a choice: deal with children's health problems up front, or we will all pay for it tenfold down the road. Morally, economically, and medically, keeping children well and preventing illness make good economic sense. Taking a piecemeal approach to health care reform will only exacerbate an already challenged system. Without systemic reform, children's health and educational outcomes are not likely to improve.

Once health care reform enables all children and youth to be financially able to use primary and required specialty care, a need to establish an effective delivery system will remain. That delivery system should be prevention oriented, ensure linkages with an ongoing medical home, collaborate with other human service delivery systems such as education, and focus on the family, realizing that the family's support for children and youth have a major impact on their health.

The Health Security Act addresses this by allowing the flexibility of local governments to integrate existing federally-funded categorical health education programs with the new comprehensive school health education program, targeting locally relevant priorities based on community needs assessment and ensuring integration of other human services.

It is important to note that these new services should not lead to a new bureaucracy but, rather, remove unnecessary duplication and increase efficiency. For example, teachers and school officials would not be burdened with new professional obligations. Rather, it would add community, health, and social service resources to ongoing educational efforts to improve outcomes for children.

What we need to do is integrate service systems. We need to reach into the community to coordinate multidisciplinary services that effectively and efficiently meet our children's needs. Efforts are already underway throughout the country to implement integrated service systems. We have heard about some of them today. In fact, earlier this week, the American Academy of Pediatrics, along with 15 national organizations representing health, education, and social services, participated in a consensus building conference on integrated service systems that are community-based and school-linked. The conference participants hope to send the committee those principles in a few weeks. There was a high level of hope at the conference for the potential of such integrated service systems.

The Academy is pleased that the Congress and the President are working together to expand comprehensive school health education programs and to increase access and efficiency of service for our Nation's children. The Academy stands ready to assist the committee in any way possible to achieve these goals.

[The prepared statement of Dr. Duncan follows:]

TESTIMONY OF PAULA DUNCAN, M.D., F.A.A.P

Mr. Chairman, members of the subcommittee, I am Dr. Paula Duncan, Director of the Vermont Maternal and Child Health from Burlington, Vermont. I am here today representing the American Academy of Pediatrics as a member of its Committee on School Health. The Academy is an organization of 47,000 pediatricians dedicated to the health, safety and well-being of infants, children, adolescents and young adults. The Academy commends your efforts to explore the linkages between health care reform and improved educational outcomes.

I am especially pleased to be able to testify before the education committee because I have spent a great deal of my professional career working with, and in schools to make children healthier so that they will be better ready to learn. Prior to coming to the Vermont Department of Health, I served as a health education teacher and health services coordinator for the Burlington School District. This experience has provided me with the understanding of the importance of both health and education in the lives of our children. Health, education, and social services share the common goal of improving the well-being our nation's children. We must all take that shared commitment with us as we develop policies that affect their futures.

My testimony will focus on three issues: why a comprehensive school health program is important to our children's future, The impact of health care reform on schools; and the importance of the integration of health, education, and social services within the context of a comprehensive school health program. I am also pleased to share with the members of the subcommittee a copy of the Academy's "School Health: Policy and Practice" manual. This document was developed by the Academy's school health committee and should provide you with significant insight into our school health policies.

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The Academy would like to commend the President for including a comprehensive school health program within the Health Security Act. The legislation establishes a national framework within which states can create a comprehensive school health education programs that improves the health and well-being of students, grades K-12, by addressing locally relevant health priorities and reducing behavior patterns associated with preventable morbidity and mortality.

Comprehensive School Health Program

Schools are a microcosm of society. Whatever social, health, or political issues are present in society will manifest themselves in the school. School health has historically been underemphasized and neglected as a potential way to reach and impact a large number of children. Many of these children otherwise might have difficulty gaining access to health education and other related services.

Traditional definitions of school health deal with three areas: health services, health education, and a healthy school environment. While these are important, it is necessary now to view school health as a broader range of school-based and community-based activities. These activities coordinate education, social and health care institutions to assist families and children in preventing disease, promoting and protecting health, and minimizing the complications of health problems of school-aged children. It is important to note that school related programs in many states reach from birth to attainment of majority, especially for children with special health or educational needs.

The American Academy of Pediatrics has developed seven goals for school health programs. They are: to assure access to primary health care; To provide a system for dealing with crisis medical situations; To provide mandated health screening and immunization monitoring; To provide systems for identification and solution of students' health and educational problems; To provide comprehensive and appropriate health education; To provide a healthful and safe school environment that facilitates learning; and, To provide a system of evaluation of the effectiveness of the school health program.

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Comprehensive school health has the potential to maximize health and educational outcomes of children and youth by attempting to focus the efforts of families, community institutions, and systems that impact them. For example, the primary goal of health education, one component of a comprehensive school health program, is to provide students with the knowledge, skills, and behaviors to choose a health-enhancing life-style. Positive reinforcement for healthy behaviors based on acquired knowledge, skills, and values is a powerful method to improve health outcomes in children and youth. The school environment is rich with opportunities to implement such a model. A healthful school environment, by our definition, is one that protects both students and staff against immediate injury or disease and promotes prevention activities and attitudes against known risk factors that might lead to future disease or disability. A school's curriculum, faculty, physical plant, and support services each offer opportunities to have impact on students.

The Impact of Health Care Reform on Schools

With comprehensive health care reform, which includes comprehensive health education programs, the health status of all children will improve. With that improvement, children will be much more likely to come to school ready to learn every day of their school experience.

The Academy supports the President's health care reform initiative, and views the Health Security Act as the best vehicle proposed to date to achieve the kind of health care reform children need. Congress must move forward on comprehensive health care reform, reform that includes integrating services, or our children's health and security -- indeed their very futures -- will be at risk.

I would like to explain why the Academy believes health care reform is necessary. Children

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desperately need access to comprehensive health services. The importance of addressing child health issues must not be viewed simply as an act of compassion. Providing children and adolescents access to quality health care, with an emphasis on prevention, is the single most important economic decision that will be made in the health care reform debate. Health care reform should not merely finance existing systems of health care that focus on treatment rather than prevention. Mr. Chairman, as you and other members of Congress consider the health care reform legislation, you face a choice: deal with children's health problems up front, or we all will pay for it ten-fold down the road. Morally, economically, and medically, keeping children well and preventing illness makes good economic sense. Taking a piecemeal approach to health care reform will only exasperate an already challenged system. Without systemic reform, children's health and educational outcomes are not likely to improve.

Integrated Services

Once health care reform enables all children and youth to be financially able to utilize primary and required specialty medical care, a need to establish an effective delivery system will remain. That delivery system should: be preventively oriented; ensure linkages with an ongoing medical home; collaborate with other human service delivery systems such as education; and focus on the family, realizing that family supports for children and youth have a major impact on health.

The Health Security Act addresses this by allowing the flexibility of local governments to integrate existing federally funded, categorical health education programs with the new comprehensive school health education program, targeting locally relevant health priorities based on community needs assessment and ensuring integration of other human services.

In order to raise awareness of the need for coordinated approaches to improving health and educational outcomes for children, and in order to forge the links required to implement the goals of a comprehensive school health program, it probably will be necessary to form or modify existing groups to form a "child/youth health council." This group should include top leadership from all groups who have or should have a stake in influencing the health and educational outcomes of children, youth, and families. This will likely include individuals who perhaps have not had much experience working together. In addition to the schools, both private and public health departments, social services departments, community colleges and universities, hospitals, and business and labor groups should be included.

Chairman OWENS. Thank you.

Dr. Cooper.

Mr. COOPER. Mr. Chair, thank you for this opportunity.

I want to digress for just a second and note that you congratulated us for sticking around and enduring, but we also congratulate you for sticking around and enduring this process. I am from Louisiana and worked with our State legislature a good bit before I came to Washington, when we faced this same kind of issue. Since often, our chairperson wasn't even at our hearings, we do appreciate you being here.

I represent NASHEC as executive director. NASHEC is the National School Health Education Coalition, and our member organizations are half education and half health related. We represent the American Cancer Society and the March of Dimes as well as the National Education Association and the National School Boards Association. We are made up of over 70 national organizations, which have come together to advance one of our common beliefs; that education and health are interrelated. We have heard a great deal of testimony today linking comprehensive health programs to the success of both of those issues, health and education.

We believe that this bill is a major step forward although we do have some technical amendments which have already been related to the committee. I want to spend some time with two issues: the urgency for keeping intact the health education and health services pieces in the legislation. We feel keeping those pieces intact is a major step forward. We also hope to protect the levels of funding currently in the bill. Although some people would argue that those levels are not enough, we believe that those kinds of dollars going down to the States and the local levels will have a major impact.

Prior to being executive director, I was a university professor, State director of special education in Louisiana, and a local school superintendent. I had the good fortune of implementing a school health program in a local district that was 50/50 black and white, the sixth poorest parish in per capita income in the State of Louisiana. Five years ago when we implemented this program, which does all the things you have already heard about today, we had about 30 percent of our kids scoring above the national average on the California Achievement Test. This past year, we have over 50 percent of our kids scoring above the national average. We currently have one of the lowest dropout rates. The only thing we changed was to put in health curriculums, and health services in the schools. We didn't spend a lot of money on computers and we didn't spend a lot of money on new text books. We said to our teachers "If you provide these you will allow us to bring in people who can assist children in maintaining good mental health, great self-esteem, and physical health, your job as a teacher will be much easier, you will be able to teach better, and our children will be able to learn better."

That is one of the things that I would like to bring to you today, not as a national representative but as an administrator freshly out of the local districts where these things have been implemented. Not in the magnet school concept but with kids that need help just like you have, whether it be in New York or North Carolina or Louisiana.

That brings me to another issue, one that we believe in NASHEC and that I believe personally after over 20 years of experience in this field. We are embarking again on education reform, and one of the things that we have learned over the last 10 or 15 years, no matter how much ballyhoo, how many great programs, how much we say we want to raise our expectations and heighten graduation standards, expect more of our teachers, and have longer schooldays to be like the Japanese, what we have found over the last 10 years is that our kids are worse off now than they were 10 years ago when these academic reforms came into play.

One of the things that was missing was this whole issue of health. If kids aren't healthy, they are not going to learn. We can evaluate teachers until the sun goes down and it is not going to make any difference.

So one of the things that this and other committees must understand is that before we embark on spending billions and billions and billions of dollars on education reform again, we must address the health needs of children.

I am a special education person by background; I have taught and was State director of special education; and what I understand now very clearly after working in this field for 20 years and seeing billions and billions of dollars spend on special education programs, is that although they have helped a lot, there is no data except in the most severe cases, that many of these programs have done any good. We have served to separate children. If we separate children in K through 12, why do we expect that they won't kill each other when they get out of school?

Comprehensive health services and comprehensive health programs begin to lessen the chance that a child getting behind in school is labeled special education, no matter what his dad's name or his mother's name, his color, or his means. I am picking on this program because it is one of my own programs. We must ensure that he is not given a label which, in fact, the people who wrote that law back in 1975 and 1978 intended to happen. Today we lower expectations, and we toss those kids out, and lots of them end up in jails and places where we don't want them to be.

So I guess I would end by saying, just tapping on my own experiences and those of Terrell Bell, who is a former commissioner of education and who actually wrote part of "A Nation At Risk." There was a recent article, and he says 10 years after this "Nation At Risk" was written, "We are looking at American education, and it is a splendid misery. We have missed the boat." He says that we spend too much time on academic reforms and not enough time addressing the health needs of children.

Thank you.

[The prepared statement of Mr. Cooper follows:]

DR. PAT COOPER, EXECUTIVE DIRECTOR

Mr. Chair and members of the subcommittee, I very much appreciate the opportunity you have given NaSHEC to testify concerning the Health Security Act and what implications it has for schools and the children and youth who attend them. I come to you today as Executive Director of the National School Health Education Coalition, commonly known as NaSHEC. And, I also come with the experiences of having been in the midst of education reform for the last twenty years as a teacher, a university professor, a State Director of Special Education Services, and most recently as a local school system superintendent.

NaSHEC is an organization comprised of over seventy national, state, and local education and health agencies, organizations, and corporations. Members include such health organizations as the March of Dimes Birth Defects Foundation, American Academy of Pediatrics, American Cancer Society, and the American Heart Association among many others. Education-related organizations include, among others, the American Association of School Administrators, National Association of State Boards of Education, Association for the Advancement of Health Education, and the National Education Association. A complete membership list is included with the written testimony.

While NaSHEC member organizations represent diverse backgrounds and interests, they all hold one belief in common . the education and health status of our children and youth are interrelated. NaSHEC endorses comprehensive school health programs that include the following components: health education, health services, physical education, nutrition services, counseling/psychological/social services, a healthy school environment, health promotion for staff, and parent/community involvement. NaSHEC believes that comprehensive health programs must assure that school-wide policies support and reinforce what is taught in the classroom. Thus, tobacco-free schools are essential to preventing the initiation of tobacco use by children and to reinforcing student knowledge of the health hazards of tobacco use. NaSHEC strongly supports the assurance in legislation that every student, grades pre-k through twelve, receive a comprehensive school health experience through both health education programs and health services programs.

Members of NaSHEC believe that the Health Security Act has great potential for positive impact on our children and youth through the inclusion of the comprehensive school health education programs and school-related health services pieces within the Act. There are technical amendments that we would suggest, and while those will be brought to the attention of individual members, the overwhelming consensus of our member organizations is that this bill is a major step forward. It both acknowledges the very real problems and the obstacles our children and youth face as well as attempting to bring to bear resources to begin to solve those problems and surmount those obstacles.

The balance of my testimony today concerns what we believe to be two overriding issues: 1) the urgency associated with keeping intact the school health education programs and school-related health services sections contained in Subtitle G, and 2) the necessity of specifically appropriated funding that matches at least the levels currently written into the Act rather than again relegating these programs to a lower priority where they must compete for funding.

NaSHEC is convinced as an organization that only with this priority status will we in this country be able to make a dent in the increasing physical and emotional morbidity and mortality rates of our children and youth. And, while we recognize that this is a health bill, it is also readily recognized that this bill has major implications for reducing the educational and economic morbidity and mortality rates of those same students. This legislation will make that dent!

We all continually talk about being in the midst of an education crisis or an economic crisis or a violence crisis, but what we are really in the midst of is all the symptoms of

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a long-running and ever-worsening public health emergency! It is this public health crisis of our children, in fact, that has spawned the education crisis, the economic crisis, and the violence crisis that those same children are grappling with today. And, while it may be necessary to continue to place dollars into categorical programs for violence prevention, drug abuse prevention, and health care, we believe that approach is not the key to solving the problems of our students. Instead, NaSHEC members believe that key lies in early, systematic, and ongoing health education programs and health care services. Those programs will enable our children to not only make enlightened decisions concerning their well-being and their future but to also take part more fully in the education process with a greatly reduced mental and physical illness liability potential hanging over their heads. This legislation will enhance those education opportunities and reduce that illness liability!

Tapping into my own experiences and the data about our children and youth that all of us see every day, the conclusion many of us reach is that our children, as a whole, are in a worse condition than they were ten or fifteen years ago when our latest round of education reform began. Giving it the just recognition it deserves, in 1983, "A Nation At Risk" was published, and there was generated an abundance of excitement, hope, optimism, and a well-intentioned desire to improve Americas's education system as well as American society in general. And although much positive came out of that and ensuing efforts, what has become clear is that crucial ingredients were left out. Those essential ingredients had to do with assuring: 1) more locally controlled and directed decision-making (therefore more responsibility); 2) more local flexibility in both the use of dollars and program determination as defined by local needs and community desires; and perhaps most important and relevant to today's hearing, 3) that the physiological, safety, emotional, and self-esteem needs of students were addressed in order for education reform, in the pure academic sense, to be successful. Numerous national studies and reports, such as the American Association Of Administrators' "Healthy Kids for the Year 2000: An Action Plan for Schools" and the National Association of State Boards of Education and the American Medical Association report entitled "Code Blue: Uniting for Healthier Youth" reinforce the fact that students have to be healthy to learn. The enactment of this piece of legislation, although thought of as health legislation, will perhaps be the most important step this country and this Congress can take in salvaging education reform!

Even some of our most respected authors of the original "A Nation At Risk" agree that we may have miscalculated. Terrell Bell, a former U.S. Commissioner of Education, and one of the authors, wrote about this admission in a recent issue of "Phi Delta Kappan", a professional education journal. In that publication he acknowledges the failure of the categorical, controlled, pure academic approach to reform. He said, "The top-down reforms of the eighties were, for the most part, ineffective according to the available data." He goes on to confess that, "we placed too much confidence in school reforms that affected only six or seven hours of the child's life in school and ignoring the other eighteen hours each weekday plus the hours on weekends and holidays." And finally he says, as do many of us in the field, that, "The ten years since the publication of 'A Nation At Risk' have been a splendid misery for American Education." What he is saying, I believe, is that improved test scores, lower drop-out rates, and the other desired outcomes we all want for our children cannot be attained by simply changing mandated academic standards and procedures. We must pay attention first to the child's most basic needs which revolve around his or her physical and mental health. The Health Security Act, contains the provisions to alleviate that misery to which Mr. Bell alluded. This bill speaks to the truism,"education leads to health and health leads to education." They are inseparable and dependent!

It is my opinion, and the opinions of many others, that as educators of our children and youth, we will surely fail in our mission without health education programs and health services becoming an integral part of every child's life and every school system's mission. We can inexhaustibly evaluate and rate teachers, and we can raise academic standards to the highest levels, and that will look good on paper for us as educators! But until our children are given quality health education programs and are helped to be healthy, both mentally and physically, the glimmer of hope for success is indeed dim. And, the implication of failure reaches beyond the individual child in this case. It reaches into our very existence as a democratic nation. America won't work if democracy doesn't work. Democracy won't work if education doesn't work. Education won't work if comprehensive health education programs and services don't work. And comprehensive health programs won't work if this piece of legislation doesn't!

In this land of the free many of our children are not free. Some them are not free because they are not healthy. We know it and they know it. Some are not healthy because they cannot access equal opportunities. Some are not healthy because of their minority status and the racial hatred they must endure. Some are not healthy because of poverty ,and some are not healthy because they are female and are teenage mothers. Some are not healthy because of violence, drugs, and guns in their environment. All of them are not healthy because collectively, together as a nation, we have been so far unable to make them healthy and, therefore, free.

Schools are where the children are, a captive audience for a short period of time. Schools can be freedom's nest rather than its graveyard, as it is all too often for many of our young. This legislation, with its commitment to school health education programs and school-related health services, we believe, can bring our children to flight, and can help to make them free!

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NaSHEC, Inc. Membership

1994

NATIONAL

American Academy of Family Physicians
American Academy of Ophthalmology
American Academy of Pediatrics
American Association of School Administrators
American Cancer Society
American College Health Association
American Foundation for Vision Awareness
American Health Foundation
American Heart Association
American Lung Association
American Optometric Association
American School Health Association
Association for the Advancement of Health Education
Association of Junior Leagues International, Inc.
Association of State and Territorial Directors of Public Health Education
Association of State and Territorial Health Officials
Center for Population Options
The Chickering Group
Comprehensive Health Education Foundation
Council of Chief State School Officers
Education Development Center
ETA Sigma Gamma
ETR Associates
Harvard School Health Education Project
March of Dimes Birth Defects Foundation
Metropolitan Life Foundation
National Association of Elementary School Principals
National Association of School Nurses, Inc.
National Association of State Boards of Education
National Center for Health Education
National Commission on Correctional Health Care
National Education Association, Health Information Network
National School Boards Association
National Scoliosis Foundation, Inc.

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Executive Director

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NaSHEC, Inc. Membership (continued)

NATIONAL Con't

New York Academy of Medicine
Sex Information and Education Council of the United States
Society of State Directors of Health, Physical Education and Recreation
Society for Public Health Education, Inc.

FEDERAL LIAISON

Adolescent Pregnancy Program, Department of Health & Human Services
Center for Substance Abuse Prevention
Division of Adolescent and School Health/CDC
Division of Cancer Prevention and Control/CDC
Department of Defense
Department of Justice, Drug Enforcement Agency
Food and Nutrition Information Center/National Agricultural Library
Food and Nutrition Service/U.S. Dept. of Agriculture
Indian Health Service
Maternal and Child Health Bureau and Resources Development
National Cancer Institute
National Center for Health Statistics
National Heart, Lung, and Blood Institute
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U.S. Department of Education
  Office of Elementary and Secondary Education
U.S. Food & Drug Administration
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CORPORATE MEMBERS

Illinois Prevention Resource Center
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Macro International
Tambrands, Inc.
The Children's Health Market, Inc.
The Learning Partnership
Very Special Arts

NaSHEC, Inc. Membership (Continued)

STATE

Illinois Chapter of the American Academy of Pediatrics
  Comprehensive Health Education Task Force
Indiana Coalition for School Health
Louisiana Council for Comprehensive School Health
Maine School Health Education Coalition
Missouri (coalition in formation)
New Jersey State Department of Education Coalition
  for Comprehensive School Health, Safety and Physical Education
New York (coalition in formation)
Oregon School Health Education Coalition (OrSHEC)
State Planning Committee for Health Education in Ohio
Tennessee School Health Coalition, Inc.
Texas Comprehensive School Health Initiative
Wyoming (coalition in formation)

LOCAL

Chester County (PA) School Health Education Coalition

Revised January 31, 1984

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Chairman OWENS. Thank you.

Ms. Welburn.

Ms. WELBURN. Good morning, Mr. Chairman—good afternoon, I should say. Thank you for this opportunity.

As you noted, our testimony will be entered into the record and so I am not going to read mine. But I would like to remark on a few observations I have made as the morning has progressed.

My name is Brenda Welburn and I am the executive director of the National Association of State Boards of Education. We issued a report several years ago entitled "Code Blue," which talked about health needs and the need for comprehensive school health. Some of our recommendations are reflected in the legislation, and we are very, very pleased about that.

But as I listened this morning, particularly to the questions that came from your colleagues and some of the comments, I realized how far we still have to go to help policymakers and the public in general recognize what school reform is.

When we ask whether or not we can add these burdens to schools, I suspect people are still seeing schools in the same mode of Carnegie units and 42-minute periods. Clearly if we are going to restructure schools, use the building, the classroom, the day, the time, in a very different way, then our ability to provide services and comprehensive health education will be reflected in that. So the question becomes, Can schools take this on? Schools as they are currently structured, cannot take it on but they also can't take on the high-level skills that we are asking children achieve in the same way. Therefore, I would continue to urge all of the members to look at comprehensive school health as another area of school reform and an arm of that school reform.

The need for professional development is keen because teachers were not trained to work in these new kinds of schools and new kind of structures. If health is going to be a part of schooling, I would encourage continued professional development, and pressure schools of higher education to train teachers to help them understand and recognize the health needs of children and the health education needs of children.

We can teach comprehensive school health in almost any discipline that we bring into the classroom. The key is to make sure we have the appropriate curricula and opportunities for teachers to gain that knowledge.

The other observation that I would make is that so often those of us who support school-site and school-linked health services are seen as anti-abstinence. Nothing could be further from the truth. I think what we do recognize is that there are skills that we have failed to teach young people in terms of making decisions about whether or not to begin sexual activity. The fact that we want young people to say no is very clear, but we have to teach them how. We have to give them options for their spare time and make them feel good about themselves. Too often young people become sexually active because their self-esteem is vested in those kinds of relationships. We want their self-esteem vested in their goals and their futures and the things that are important to them. Nothing is further from the truth than believing we don't want abstinence taught as a viable alternative.

Finally, I have to say that even as a working mother with insurance, access to health care is not always easy. My doctor's, my schedule, and my children's schedules are always on a collision course, and rarely does the physician change his schedule. When someone misses work or school, I think school-linked and school-site services appear even more valuable because we know how important it is to have our children have access to services.

So I would add that to the remarks that will be entered, and I thank you again for the opportunity.

[The prepared statement of Ms. Welburn follows:]

Brenda Lilienthal Welburn
Executive Director

MY NAME IS BRENDA WELBURN AND I AM THE EXECUTIVE DIRECTOR OF THE NATIONAL ASSOCIATION OF STATE BOARDS OF EDUCATION. NASBE REPRESENTS STATE BOARDS OF EDUCATION, WHO ARE POLICYMAKERS AND ADVOCATES FOR THE MORE THAN FORTY MILLION CHILDREN AND YOUNG PEOPLE IN OUR NATION'S PUBLIC SCHOOLS.

CHAIRMAN OWENS AND MEMBERS OF THE SUBCOMMITTEE, I AM PLEASED TO BE HERE TO TODAY TO DISCUSS AN IMPORTANT NEW FEDERAL "CHILD-CENTERED" INITIATIVE IN WHICH THE EDUCATION SYSTEM, HEALTH AGENCIES, OTHER SERVICE AGENCIES, FAMILIES AND COMMUNITIES ALL SHARE RESPONSIBILITY FOR CHILDREN'S HEALTH, EDUCATIONAL ACHIEVEMENT, AND GENERAL WELL-BEING. MY TESTIMONY TODAY WILL FOCUS ON TWO OF THE PUBLIC HEALTH SERVICE PROVISIONS OF THE LEGISLATION: THE COMPREHENSIVE SCHOOL HEALTH EDUCATION GRANTS AND THE SCHOOL HEALTH RELATED SERVICES GRANTS. THE NATIONAL ASSOCIATION OF STATE BOARDS OF EDUCATION STRONGLY SUPPORTS THESE PROGRAMS AND WILL WORK WITH YOU TO ENSURE THEIR PASSAGE.

AS YOU ARE WELL AWARE, SIGNIFICANT EFFORTS ARE UNDERWAY AT STATE, NATIONAL AND LOCAL LEVELS TO IMPROVE STUDENT LEARNING AND TO PRODUCE GRADUATES WHO CAN READ, WRITE, COMPUTE, COMMUNICATE AND THINK AT A HIGH LEVEL. WE CANNOT HOWEVER EXPECT STUDENTS TO MEET HIGH ACADEMIC STANDARDS IF WE DO NOT PROVIDE THEM AND THEIR COMMUNITIES WITH THE SUPPORTS AND RESOURCES NECESSARY TO MAKE THESE HIGH EXPECTATIONS A REAL POSSIBILITY FOR EVERY CHILD. NEW EDUCATION MODELS CALL FOR NEW KINDS OF COORDINATING ROLES AND FUNCTIONS WHICH MIGHT BE FILLED BY A VARIETY OF PEOPLE TO CAPITALIZE

ON THE STRENGTHS OF DIFFERENT PROFESSIONS IN ORDER TO ENSURE THAT THE SOCIAL, EMOTIONAL, AND PHYSICAL HEALTH NEEDS OF CHILDREN ARE FULLY MET.

STATES AND LOCAL COMMUNITIES, IN PARTNERSHIP WITH THE PRIVATE SECTOR, HAVE MADE SIGNIFICANT STRIDES IN FORMING AND PROMOTING IMPORTANT ALLIANCES TO INCREASE THE AVAILABILITY OF HEALTH CARE TO CHILDREN. WE AT THE NATIONAL ASSOCIATION OF STATE BOARDS OF EDUCATION BELIEVE IT IS TIME FOR THE FEDERAL GOVERNMENT TO TAKE AN ACTIVE ROLE IN THESE PARTNERSHIPS. LAST YEAR, THE ROBERT WOODS JOHNSON FOUNDATION RECEIVED APPLICATIONS FROM 46 STATES FOR FUNDS TO DEVELOP SCHOOL-BASED HEALTH SERVICES. THESE APPLICATIONS REFLECTED THE STRONG DESIRE IN LOCAL COMMUNITIES TO BUILD CAPACITY AT THE SCHOOL SITE FOR INCREASED HEALTH EDUCATION AND SERVICE PROGRAMS. UNFORTUNATELY, THE JOHNSON FOUNDATION WAS ONLY ABLE TO FUND A DOZEN OR SO OF THEIR PROPOSALS. THE NEED AND THE INTEREST IS EXTENSIVE, AND THE PROGRAMS OUTLINED IN THE HEALTH SECURITY ACT CAN HELP STATES EVEN WITH THE SMALL AMOUNT OF AUTHORIZED FUNDING.

MR. CHAIRMAN, IN 1989, TOGETHER WITH THE AMERICAN MEDICAL ASSOCIATION, NASBE COSPONSORED THE NATIONAL COMMISSION ON THE ROLE OF THE SCHOOLS AND THE COMMUNITY IN IMPROVING ADOLESCENT HEALTH. THE COMMISSION'S FINDINGS AND RECOMMENDATIONS WERE PUBLISHED IN A DOCUMENT ENTITLED CODE BLUE: UNITING FOR HEALTHIER YOUTH. WE CHOSE TO CALL THE REPORT "CODE BLUE" BECAUSE WE SINCERELY BELIEVED AT THE TIME THE REPORT WAS ISSUED, AND WE STILL BELIEVE TODAY, THAT THE DECLINING AVAILABILITY OF HEALTH SERVICES FOR OUR CHILDREN AND YOUTH HAS REACHED A STATE OF EMERGENCY. IT IS AFFECTING NOT ONLY THEIR PHYSICAL AND EMOTIONAL WELL-BEING; IT IS IMPEDING THEIR ABILITY TO LEARN.

CODE BLUE CONTAINS FOUR ESSENTIAL RECOMMENDATIONS WHICH NASBE IS PLEASED TO SEE REFLECTED SOMEWHAT IN THE SCHOOL HEALTH PROGRAMS PROVISIONS OF THIS LEGISLATION. WHILE OUR RECOMMENDATIONS FOCUSED ON ADOLESCENTS, THE AGE GROUP THAT IS MOST UNDER SERVED, WE BELIEVE THEY APPLY EQUALLY WELL TO ALL CHILDREN. THOSE RECOMMENDATIONS INCLUDE:

- A GUARANTEE THAT ALL ADOLESCENTS HAVE ACCESS TO HEALTH SERVICES REGARDLESS OF ABILITY TO PAY;
- A COMMITMENT TO MAKE COMMUNITIES THE FRONT LINE IN THE BATTLE FOR ADOLESCENT HEALTH;
- A PROCESS THAT ORGANIZES SERVICES AROUND PEOPLE, NOT PEOPLE AROUND SERVICES;
- SUPPORT TO ASSIST SCHOOLS PLAY A STRONGER ROLE IN IMPROVING ADOLESCENT HEALTH.

THE COMPREHENSIVE SCHOOL HEALTH EDUCATION PROGRAM RESPONDS TO THESE RECOMMENDATIONS IN SEVERAL WAYS. THE BILL WOULD REQUIRE COORDINATION BETWEEN THE STATE EDUCATIONAL AND HEALTH AGENCIES IN THE DEVELOPMENT AND IMPLEMENTATION OF THESE PROGRAMS. IN ORDER TO STRENGTHEN THAT IMPORTANT PARTNERSHIP, NASBE URGES YOU TO AMEND THE BILL SO THAT THE U.S. DEPARTMENT OF EDUCATION ADMINISTERS THIS PROGRAM JOINTLY WITH THE DEPARTMENT OF HEALTH AND HUMAN SERVICES. THERE IS PRECEDENCE FOR JOINT FEDERAL ADMINISTRATION OF INTEGRATED PROGRAMS IN THE SCHOOL TO WORK OPPORTUNITIES ACT WHICH THE HOUSE OF REPRESENTATIVES PASSED LAST

SESSION. NO LESS OF A PARTNERSHIP WILL BE REQUIRED AT THE FEDERAL LEVEL IN ORDER TO REACH THE GOALS OF THIS PROGRAM.

WE COMMEND THE ADMINISTRATION FOR THE FOCUS AT THE STATE LEVEL ON PROFESSIONAL DEVELOPMENT, TECHNICAL ASSISTANCE TO LOCAL DISTRICTS, AND INVOLVEMENT OF FAMILIES AND THE COMMUNITY IN PROGRAM ACTIVITIES. AMONG THE CHALLENGES STATE BOARDS OF EDUCATION FACE IN THIS ERA OF REFORM IS THE DEVELOPMENT OF NEW STANDARDS FOR TEACHER SKILL COMPETENCIES IN THE REVISION OF THE CERTIFICATION AND LICENSURE OF TEACHERS. WE WANT EVERY TEACHER TO BE ABLE TO SUPPORT STUDENTS' SOCIAL AND EMOTIONAL HEALTH DEVELOPMENT AND TO USE CURRICULA THAT IS CONSISTENT WITH NEW LEARNING AND TEACHING STRATEGIES.

THE RESEARCH IS CLEAR THAT SUCCESSFUL SCHOOL COMMUNITIES CONCERN THEMSELVES WITH THE MULTIFACETED NEEDS OF STUDENTS AND STAFF INCLUDING THEIR SOCIAL, EMOTIONAL AND PHYSICAL HEALTH. THIS MEANS INTEGRATING COMPREHENSIVE HEALTH EDUCATION INTO THE LEARNING ENVIRONMENT AND INTO A VARIETY OF ACADEMIC SUBJECTS. AS WITH OTHER KINDS OF SCHOOLS REFORM, EFFECTIVE COMPREHENSIVE HEALTH EDUCATION IS BASED ON AN ASSESSMENT OF THE LOCAL NEEDS OF STUDENTS AND A PLAN OF ACTION THAT REFLECTS THOSE NEEDS.

NASBE BELIEVES THAT THE COMPREHENSIVE SCHOOL HEALTH EDUCATION PROGRAM OF TITLE III WILL PROMOTE EFFECTIVE HEALTH EDUCATION PROGRAMS. STUDENTS WILL RECEIVE RELEVANT AND APPROPRIATE INFORMATION ON A RANGE OF HEALTH ISSUES INCLUDING ACCIDENT PREVENTION, SUBSTANCE ABUSE, NUTRITION, VIOLENCE PREVENTION, HUMAN DEVELOPMENT AND MAINTENANCE OF A HEALTHY LIFE STYLE. THEY WILL BE GIVEN MORE THAN KNOWLEDGE; THEY WILL BE GIVEN THE SKILLS AND

STRATEGIES TO MAKE PRUDENT DECISIONS. IT WILL PREVENT STUDENTS FROM ENGAGING IN RISKY BEHAVIORS THAT MAKE THEM ILL, OR WORSE, CAUSE THEIR EARLY DEATH. LASTLY, IT WILL INVOLVE PARENTS, EDUCATORS AND HEALTH PROFESSIONALS, AND CONCERNED MEMBERS OF THE COMMUNITY AND REINFORCE THE IDEA THAT WE AN ENTIRE COMMUNITY HAS A VESTED INTEREST IN THE HEALTH AND WELL-BEING OF ITS CHILDREN.

THERE ARE PLACES IN THIS COUNTRY WHERE COMPREHENSIVE HEALTH EDUCATION HAS BEEN SUCCESSFULLY IMPLEMENTED. NEW YORK CITY'S "GROWING HEALTHY" AND "BEING HEALTHY" WERE DEVELOPED IN THE 1980'S TO PROVIDE A CREATIVE AND ENGAGING APPROACH TO ENABLING STUDENTS IN THE EARLIEST GRADES THROUGH HIGH SCHOOL TO LEARN ABOUT HEALTH AND ASSUME MORE RESPONSIBILITY FOR PERSONAL HEALTH DECISIONS. STUDENTS HAVE DEVELOPED BETTER RELATIONSHIPS WITH OTHERS, GREATER SELF-RESPONSIBILITY, AND ENHANCED DECISION-MAKING SKILLS.

MICHIGAN INSTITUTED COMPREHENSIVE SCHOOL HEALTH PROGRAMS IN 1974. THEY COORDINATED FEDERAL, STATE AND LOCAL RESOURCES BEHIND A PROGRAM DEVELOPED BY EIGHT STATE AGENCIES. IN 1987, IT WAS NAMED BY THE NATIONAL ASSOCIATION OF STATE ALCOHOL AND DRUG ABUSE DIRECTORS AND THE FEDERAL OFFICE OF SUBSTANCE ABUSE PREVENTION AS ONE OF TWENTY NATIONAL EXEMPLARY PROGRAMS.

OTHER STATES SUCH AS WEST VIRGINIA, GEORGIA, CALIFORNIA, TEXAS AND FLORIDA ARE ALL WORKING ON COMPREHENSIVE SCHOOL HEALTH EDUCATION PROGRAMS BECAUSE THEY BELIEVE IT IS A MORE EFFECTIVE STRATEGY TO REACHING THE GOAL OF DRUG AND ALCOHOL-FREE, SAFE, HEALTHY, AND MOTIVATED STUDENTS THAN THE CURRENT SYSTEM OF DIDACTIC CURRICULA AND FRAGMENTED APPROACHES TO ADDRESSING INTERRELATED HEALTH AND EDUCATION PROBLEMS. THIS LEGISLATION GIVES STATES THE FLEXIBILITY

AND THE SUPPORT TO BE INNOVATIVE IN THE WAYS THAT WE HELP OUR CHILDREN STAY HEALTHY AND BE LIFELONG LEARNERS.

WE BELIEVE THIS LEGISLATION WILL ENCOURAGE MORE STATES TO MOVE BEYOND TRADITIONAL NOTIONS OF HEALTH EDUCATION TO A FAR-THINKING STRATEGY THAT IMPROVES THE LEARNING ENVIRONMENT FOR STUDENTS, STAFF AND THE COMMUNITY. THIS IS EVIDENCED IN OUR TECHNICAL ASSISTANCE TO STATE BOARDS IN THEIR SUPPORT AND DEVELOPMENT OF HEALTHY SCHOOLS. WITH THE SUPPORT OF A GRANT FROM THE CENTERS FOR DISEASE CONTROL WE HAVE CREATED A HEALTHY SCHOOLS NETWORK, WHICH CONSISTS OF THIRTEEN STATES ACROSS THE COUNTRY.[1] OUR MEMBERS BELIEVE THAT AS ADVOCATES FOR CHILDREN AND YOUTH THEY MUST PROVIDE GUIDANCE AND LEADERSHIP FOR SCHOOLS TO MOVE BEYOND CURSORY INSTRUCTION IN HEALTH TOPICS. THE HEALTHY SCHOOLS NETWORK HAS ADOPTED THE FOLLOWING DEFINITION OF A HEALTHY SCHOOL. A HEALTHY SCHOOL IS ONE THAT INTEGRATES COMMUNITY, FAMILY AND SCHOOLS TO PROVIDE FOR STUDENTS A POSITIVE CONTINUUM OF INTELLECTUAL, PHYSICAL, SOCIAL, AND EMOTIONAL DEVELOPMENT ON WHICH TO BASE LIFE-LONG DECISIONS.

A HEALTHY SCHOOL FOLLOWS SEVERAL PRINCIPLES. IT ENSURES A HEALTHY SCHOOL CLIMATE WHERE BOTH STUDENTS AND TEACHERS ARE TREATED WITH RESPECT AND FEEL VALUED; WHERE HIGH EXPECTATIONS ARE HELD FOR ALL STUDENTS; WHERE PARENT AND COMMUNITY INVOLVEMENT IS MEANINGFULLY INTEGRATED IN THE SCHOOLS AND STUDENTS PARTICIPATE IN SCHOOL AND COMMUNITY ACTIVITIES. A HEALTHY SCHOOL PROVIDES EFFECTIVE HEALTH EDUCATION THAT IS COMPREHENSIVE, HONEST, RESEARCH-BASED, DEVELOPMENTALLY APPROPRIATE, AND USES A VARIETY OF INSTRUCTIONAL

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[1] The states participating in NASBE's Health Action Network are Arkansas, California, Georgia, Iowa, Kansas, Kentucky, Maryland, Michigan, New Mexico, Oregon, South Dakota, Utah, and West Virginia.

TECHNIQUES. IT ASSURES ACCESS TO PREVENTIVE HEALTH AND OTHER SERVICES IN WAYS APPROPRIATE TO LOCAL NEEDS AND CIRCUMSTANCES.

NASBE ALSO SUPPORTS THE SCHOOL HEALTH-RELATED SERVICES PROGRAM AND HOPES THAT THE BILL WILL BE STRENGTHENED AS IT MOVES THROUGH THIS SUBCOMMITTEE BY ENHANCING THE COORDINATION OF THIS PROGRAM WITH THE COMPREHENSIVE SCHOOL HEALTH EDUCATION GRANTS. SCHOOLS ARE WHERE STUDENTS ARE AND LOGICALLY A NATURAL DELIVERY SITE FOR SERVICES. WE KNOW THAT MANY STUDENTS, PARTICULARLY ADOLESCENTS, ARE MEDICALLY UNDER SERVED DESPITE THEIR NEED FOR PHYSICAL AND MENTAL HEALTH SERVICES. AND NASBE HOPES, THAT SERVICES WILL BE OFFERED ON A SCHOOL-WIDE AND COMMUNITY-WIDE BASIS RATHER THAN RESTRICTING SERVICES TO A PARTICULAR AGE LIMIT. SCHOOL HEALTH SERVICES HAVE BEEN WELL-RECEIVED AND SUCCESSFUL WHEN THEY ARE DESIGNED TO SERVE THE ENTIRE STUDENT COMMUNITY. ANY COMMUNITY PARTNERSHIP THAT RECEIVES A GRANT UNDER THIS PROGRAM, MUST COMMIT ITSELF TO SERVING ADOLESCENTS AS WELL AS YOUNG CHILDREN.

ALL OF THESE EFFORTS ARE SORELY NEEDED AND WILL REAP GREAT BENEFITS FOR SOCIETY AS A WHOLE, BUT THEY WILL REQUIRE AN INVESTMENT OF RESOURCES. COMPREHENSIVE SCHOOL HEALTH EDUCATION HAS BEEN IMPLEMENTED IN OTHER STATES LARGELY THROUGH FUNDS FROM THE CENTERS FOR DISEASE CONTROL AND MORE IS NEEDED.

MR. CHAIRMAN OUR LAST CONCERN WITH THIS BILL IS THAT IT DOES NOT PROVIDE SPECIFIC FEDERAL FUNDING FOR SCHOOL HEALTH PROGRAMS. IT FORCES SCHOOL HEALTH TO COMPETE WITH OTHER EDUCATION AND PUBLIC HEALTH PROGRAMS FOR RESOURCES. I URGE YOU TO AMEND THE BILL TO GUARANTEE A SPECIFIC INVESTMENT IN SCHOOL HEALTH EDUCATION PROGRAMS AND SERVICES.

FOR SEVERAL YEARS, NASBE HAS BEEN WORKING WITH STATE EDUCATION POLICYMAKERS IN IMPLEMENTING SCHOOL HEALTH PROGRAMS. WE ARE DELIGHTED THAT THE FEDERAL GOVERNMENT IS WILLING TO HELP US EXPAND SUCH EFFORTS. DO NOT LET THIS MOMENTUM EBB OR DISAPPEAR. THE HEALTH AND EDUCATIONAL SUCCESS OF OUR NEXT GENERATION DEPENDS ON YOUR COMMITMENT TO THESE PROGRAMS.

THANK YOU.

Chairman OWENS. Thank you.

You mentioned, and I think on the previous panel Mr. Lubin mentioned, training for teachers in the area of health care. We get complaints frequently from teachers that there are always some new recommendations for new kinds of training for them to keep their development going. What about the health care personnel? To what degree will people who are directly related to health care relieve the teachers of this added burden?

Ms. WELBURN. I think as we talk about cross-discipline instruction, teaching, and differently configured classrooms, we are talking about a teacher who teaches math or reading or English being able to work with that health education person, not only to reinforce what the health education teacher is teaching, but to use curricula and examples in literature and in science to reinforce that.

I don't think we can expect a teacher to be isolated on any one issue any more. Knowledge explosion is too great for that. The important thing is to help teachers learn to work better to access information right in their own school building with the health personnel that may be on site. If we don't structure classrooms differently than we do now, we can't expect teachers to be able to do that.

Chairman OWENS. Dr. Cooper, you made some pretty ambitious claims for the achievements of health services. In relation to a question that one of my colleagues asked earlier, what kind of personnel and staffing make up an optimum ratio of personnel to students for a school-based or school-linked health services operation?

Mr. COOPER. I think all of us are struggling with that right now, and I am going to tell you, I don't know optimum ratios. I wish I did; it would make life a lot easier. A lot of that depends on the school system and the kinds of kids and the age of the children and whether it is in a poverty area where there is a lot of teenage parenting going on. I am not trying to evade your question, but quite frankly none of us knows that.

Chairman OWENS. Well, what does a typical unit look like?

Mr. COOPER. We wanted to start ours at elementary schools, and that is where we put our initial family service center. We did a lot of outreach for early childhood, birth to three-year-old children, that were born in what I call deficit situations. These situations include poverty, disability, and teenagers that were single mothers.

We did a lot of outreach with what we called home visitors. These visitors went into the homes to find out what was going on, and then lured those people back into the schools so that they could be treated by nurses, pediatricians, and psychiatrists. A lot of it was paid for by existing dollars that we already had in the school system, but a lot of it was paid for by the Medicaid reimbursement that was referred to earlier. We had a full array of services, including some dental services. Anything that you could think of that a child might have in a regular health setting was provided to those children if they needed it.

The obvious problem we ran into was that wealthier children who need just as much mental health counseling and sometimes just as many health services, weren't eligible for Medicaid. We had to try to figure out different ways to use our drug-free schools dollars, our Chapter 1 dollars, and our special education dollars.

Chairman OWENS. You couldn't bring the welfare children into Medicaid?

Mr. COOPER. No, we couldn't bring the wealthier since they didn't qualify. The welfare children and the free and reduced lunch children we had access to.

Chairman OWENS. I was going to ask you about Dr. Witucki's testimony regarding Medicaid reimbursement for services for students in special education programs and what you thought of that.

Mr. COOPER. We started that back in 1988 and then moved on to non-special education children who also qualified by virtue of being free and reduced lunch. I think it works differently in different States, but we were able to use those same Medicaid dollars to access children who weren't labeled special education, who had the same kinds of problems.

We did preventative screening. We got a lot of dollars from Medicaid that we pumped back into the program, and those are some of the dollars that we used to access some of the wealthier children who wouldn't qualify under Medicaid, who needed mental health counseling.

So there are ways to do it out there now, but it is a struggle. You have to practice what I call as a school superintendent almost civil disobedience because the State legislators——

Chairman OWENS. I wonder if you want some of this on the record.

Mr. COOPER. Well, I am not going to incriminate myself or anybody else, but we had to argue a long time to convince people that you could use some of these categorical dollars in these ways. What we found out was that indeed it was legal, but tradition would say no, don't use them that way.

Chairman OWENS. I was fascinated by your contention that the only thing that changed in the schools was the provision of the health services and then scores jumped on the tests. Would you say that health care services are a way of increasing students' sense of self worth and raising their self-esteem?

Mr. COOPER. Absolutely.

Chairman OWENS. Individual attention in a very special way that has an impact on the way they approach it?

Mr. COOPER. There is no question about it. I don't want to be flippant here about how this has to work, but we had to go to our State level folks, for instance, our drug-free schools money, and we would buy red ribbons and scream, "Just say no," and what we found is that we don't have a decrease in drug use with our children, we have an increase.

So we asked them to use some what I call higher order thinking skills and said, "All right follow me here. Instead of buying 100,000 yards of red ribbon, let me buy five or six additional teachers' aides or health aides, put them in the classrooms with children, and in effect it lowers the pupil-teacher ratio. We have more individual attention and you have less frustrated learners because they don't fall through the cracks. If you have less frustrated learners, you have less discipline; less discipline, less suspension; less suspension, less expulsion; less expulsion, and you have less kids out on the street hanging around shooting drugs and having illicit sex."

It took me about four times to go through that with them for them to understand that this was part of comprehensive health. This was making kids feel better about themselves, and preventing them from getting so far behind that we couldn't retrieve them.

Chairman OWENS. Dr. Duncan, could Academy get a little bit more bureaucratic and talk about the optimum ratio of personnel to students and possible costs per student?

Dr. DUNCAN. Right. Unfortunately, at this point we don't have a cost. The Robert Wood Johnson Foundation has put together what they think and what a number of experts in the country think looks like a good program, and I would be happy to send you a copy of their booklet that describes these services.

Chairman OWENS. Is that what you mentioned in your testimony?

Dr. DUNCAN. No, it is something different.

Chairman OWENS. Do we have a copy of what you mentioned in this testimony?

Dr. DUNCAN. Yes.

Chairman OWENS. The plans? Do we have a copy of that?

Dr. DUNCAN. Yes.

Chairman OWENS. The committee wants to retain that.

Dr. DUNCAN. They feel that there has to be on-site mental health services as well as physical health services, and other things right on site.

So in the school as it exists, usually there would be in a good situation a school nurse and a guidance counselor. The school nurse would focus on all kinds of health issues along with the guidance counselor. The guidance counselor in the new sense of the word is responsible for mediation and violence prevention and other kinds of non-crisis curricular activities. So the school nurse, the guidance counselor, teachers' aides, and administrators in the school, along with a school-based health service, adds a whole primary care component to schools. Usually it is collaborative practice with a nurse practitioner providing services on site, who works either with a public health physician or it could be a physician in practice.

One of the models that we would certainly implement in Vermont with school-based health services where the community decides that this is what they would like to have, would address the access problem that the kids can't get into the physicians' offices, through a collaborative practice between the physician and the school nurse in the school. There would also be 24-hour coverage for the kids after school when school is out.

In the school there would be the nurse practitioner, perhaps a clerk or someone to make sure the kids get in and out, and then a mental health professional, social worker or other mental health worker. One of the ideas is that when young people come through the door, nobody should know who they are seeing. They should be able to see either the nurse or the nurse practitioner or the mental health practitioner within the same setting so that they get their needs met in different ways.

Some numbers indicate one to 700 for school nurses; one to 350 or one to 400 would be what we would really like to see, but that isn't factoring in the school-based clinics. I don't really have any of those numbers, but we could try to get them for you, and also they may be in the book that I am talking about from Robert Wood Johnson.

We will make sure from the Academy that your committee gets whatever the different organizations recommend as their optimal numbers at least for a guess so we could have some place to start, if that would be helpful.

Chairman OWENS. It would be very helpful because what we have is rhetorical agreement that spending up front on young children, is a part of preventive health care resulting in long-term savings. In practice, even in Canada where I have visited and looked at their single payer system, there is a problem with preventive health care funding. Their funding is driven by disease and illness. When you get sick, the reimbursement flows that way. The kind of expenditures that I think we should look forward to for young children and school children will be hard to rationalize unless we can show some thorough thinking backing up the rhetoric. Everybody agrees until it comes time to pay the bill, and I would like to see the bill justified. I think it can be justified. That is the reason I am asking these kinds of questions.

Dr. DUNCAN. Great. I think we would be happy to try to look into that with the other organizations as well and try to get ratios as well as costs. Certainly we know the costs of some school-based centers, so that information should be available.

Chairman OWENS. And what kind of backup set of specialists you need to back those people up.

Dr. DUNCAN. Right. What if a child is identified with a problem that needs some subspecialty care? If the access to care becomes law, then we already have that financial component covered. We still have to make sure that the delivery system is there so it is integrated, that it makes sense from a family point of view. Families look at services and are confused. If we can get the financial aspect of this covered, then we can move on. As you were talking about earlier, school-based health services need to be included somehow.

Chairman OWENS. Yes. We would appreciate if you would comment on telemedicine and distance counseling also.

Dr. DUNCAN. The networks? The superhighway, you mean?

Chairman OWENS. Yes.

Dr. DUNCAN. I don't have very much experience——

Chairman OWENS. I don't mean now. I hope the Academy will take a look at how viable telemedicine is in some of these situations. It is being practiced, I understand, in a few places. For example, I saw a story on television the other day on its use in Austin, Texas.

And also distance learning, distance counseling, distance teaching of teachers in these specialized areas, how viable is that, and can we do a lot of that at low cost? I hope that the Academy will look into those kinds of things too.

Dr. DUNCAN. Great.

I was in a meeting in the three State in northern New England—Vermont, New Hampshire, and Maine—talking about exactly those issues. Education of physicians and teachers and other health care providers especially for rural areas like that, it is going to be very important.

One of the examples given at this meeting was admitting a patient to the hospital as a physician in an outlying area. Telemedicine can allow you to be part of the rounds on that patient at the hospital, and learn what is going on. Your patient could actually see you and feel more comfortable that his or her doctor was on the line? So we would be happy to look into that too.

Chairman OWENS. There has been some concern over the possible reduction of benefits currently available under the early and periodic screening, diagnosis, and testing program. Is that concern an obsolete one? Would that automatically be taken care of in a new health setup.

Mr. COOPER. We don't feel like there is a major concern there, although anything can happen in the future. For instance, in our case, we were a service provider as a school district, although that term wasn't used then. We did a lot of the work ourselves, and whether that service is provided through us as a school district or somewhere else, unless Congress would choose to take those dollars, we think the dollars will be somewhere.

Chairman OWENS. Well, thank you very much. You have been quite patient and quite informative. We may have some additional questions that we will send to you in writing over the next 10 days, and if you have any comments you would like to enter into the record in the next 10 days, please submit them to us.

Thank you very much again for being here.

The hearing of the subcommittee is adjourned.

[Whereupon, at 1 p.m., the subcommittee was adjourned.]

[Additional material submitted for the record follows.]

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American Heart Association
Office of Public Affairs

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American Heart Association

Statement for the Record

on

The Health Security Act

Submitted to the

House Education and Labor Subcommittee on Select Education and Civil Rights

Chairman Major Owens

Hearing on

January 26, 1994

BEST COPY AVAILABLE

The American Heart Association is pleased to see that the Clinton Administration has included comprehensive school health education in the Health Security Act. Comprehensive school health education is a critical component of preventive health services and it is something that we strongly endorse. However, comprehensive health education is only part of the whole comprehensive school health program. In order to ensure that this nation's children develop the essential knowledge and skills they will need to maintain their health and the health of their future families, we must promote both a comprehensive school health program and a healthy school environment. A comprehensive school health program must focus on, tobacco-free school environments, nutritious and healthy school meals, physical fitness activities, employee wellness programs, as well as comprehensive school health education curricula taught in the classrooms. Moreover, comprehensive school health programs must assure that school-wide policies support and reinforce what is taught in the classroom.

The American Heart Association is the nation's largest voluntary organization dedicated to reducing death and disability from cardiovascular diseases, including heart attack and stroke. The AHA is also 3.7 million volunteers who believe that what they do helps to save lives and improves the quality of those lives. Cardiovascular diseases -- mainly heart attacks and strokes -- kill more Americans than any other cause of death, including cancer and AIDS combined. Cardiovascular diseases remain the number one killer in the United States.

Public health education programs are a primary area of emphasis for the American Heart Association. Programs stress disease prevention by promoting healthy lifestyles for young people and by encouraging everyone to eat balanced nutritious meals low in fats, to not use tobacco, to control high blood pressure, and to be physically active. To that end the AHA spent $62.3 million in 1992-93. AHA educational and community service programs are offered in the nation's schools, various worksites, and in the communities. AHA interactive educational and community programs reached 38.4 million people in 1992-93. Specifically, AHA schoolsite programs, offered from pre-school through the 12th grade, involved 18.3 million youngsters (one third of all children schooled in the United States).

Even though cardiovascular diseases are the number one killer, much can be done to prevent or delay the onset of these deadly diseases. If steps such as education and appropriate behavior changes are taken in early life many cases of heart disease and stroke can be prevented. Behaviors which increase cardiovascular disease risk, such as physical inactivity, tobacco use, and poor diet, usually are established during childhood. These habits are often inter-related and persist into adulthood, and contribute simultaneously to poor health, education, and social outcomes. Most importantly these habits, and the diseases which result from these habits, are preventable. In the best interests of our country school health education programs must be employed to prevent the development of adverse health behaviors and the problems that they cause in the future. Furthermore, comprehensive school health education is a potential cost-saving strategy. In 1994 alone, cardiovascular diseases will cost this nation an estimated $128 billion in medical expenses and lost productivity. Think of the money saved if even half of the heart disease cases were prevented.

A comprehensive school health education program must address locally relevant priorities. Specifically the American Heart Association endorses comprehensive school health programs that tackle problems associated with tobacco use, poor nutrition and dietary habits, and physical inactivity as dictated by the following facts and observations.

Tobacco

Tobacco use is the single largest preventable cause of death and disability in the United States, accounting for over 419,000 deaths each year at an estimated cost of $68 billion in direct health care costs and lost productivity. Every day over 3,000 children are lured into starting the tobacco habit before they even reach the legal buying age. The 1990 report of the National Commission on Drug-Free Schools found that tobacco advertising clearly influences young people to take up the tobacco habit. It glamorizes and legitimizes tobacco usage and creates a false impression that tobacco products pose no significant health risk.

The American Heart Association believes that tobacco-free schools are essential to preventing the initiation of tobacco use by children and to protecting nonsmokers from secondhand tobacco smoke. In order for a school health program to be comprehensive, it must include both education about the hazards of tobacco and a tobacco-free school environment.

Nutrition

Proper eating habits play a large role in preventive health. High blood cholesterol and high blood pressure -- two risk factors for heart disease -- result from poor dietary patterns.

In order to attenuate the devastating consequences of heart disease and other diseases, federal dietary guidelines recommend that total fat intake should be less than 30 percent of the calories in ones diet. However, school lunches in this country derive an average of 40 percent of calories from fat. In order to help youngsters maintain their cholesterol, sodium, and blood pressure levels within a desirable range, their school meals must meet the recommended dietary guidelines set forth by the federal government. Obviously then school meals are vital to the health of this nation's children. In fact for many children, school meals provide well over half of the nutrients they need to grow and learn. For this reason school meals must be placed in compliance with federal dietary guidelines. Also school-aged children must be encouraged, through nutrition education, to maintain a healthy diet throughout their lives.

High Blood Pressure

High blood pressure is a very powerful and prevalent cardiovascular disease risk factor. Since this condition can develop in children and is easily detected and usually controllable any comprehensive school health program must include appropriately spaced high blood pressure screenings and instruction emphasizing high blood pressure awareness and control.

High Blood Cholesterol

Another risk factor for cardiovascular disease is high blood cholesterol. Among other things, cholesterol is affected by heredity, therefore, the AHA recommends that children from families with a history of premature heart attacks and/or high cholesterol levels should have their cholesterol monitored periodically by a doctor.

The comprehensive school health program must reenforce proper eating habits to help maintain children's blood pressure and cholesterol levels and to help decrease their risk of heart disease later in life. If children develop better eating habits at an early age, these habits will last a lifetime and promote better health.

Physical Fitness

Physical inactivity has been clearly ascertained to be a cardiovascular disease risk factor. This condition poses a real health threat to a generation of children that is wedded to television watching and video game playing.

Regular aerobic exercise plays a significant role in preventing heart disease and therefore, all children should be introduced to the principles of regular physical exercise and aerobic recreational activities at an early age. To help establish good health habits, the school physical education curriculum should not overemphasize sports and activities that selectively eliminate children who are less skilled. Schools should teach and emphasize that the development and maintenance of an exercise conditioning program provides rich benefits throughout ones life.

To ensure that school aged children have access to all these components of a comprehensive school health education program the state governments do not necessarily have to spend money on developing new teaching materials. Organizations, like the American Heart Association, have worked for years developing and mastering comprehensive materials for the classroom. These existing materials can and should be used where ever possible rather than developing new materials.

The AHA has developed a variety of schoolsite programs to educate teachers, students, and parents on the benefits of heart healthy living. The AHA heart healthy teaching tools begin with the *Heart Treasure Chest*. This program presents basic health concepts to children age five and under. At each higher grade level the AHA adopts more sophisticated programs until grades 10-12 culminate with *Heart Challenges*. This last school aged program promotes total cardiovascular health in the total school environment.

Other programs promoted in the school system by the AHA include *Jump Rope For Heart*. This program teaches all students the benefits of a regular exercise program. The AHA also has a program to enhance school meals. The *Hearty School Lunch Program* is a set of resource and menu manuals targeted to school food services directors to encourage the preparation of heart healthy meals, that follow the federal governments dietary guidelines, in the schools.

The American Heart Association is pleased to see comprehensive school health education in the Health Security Act, but at the same time, comprehensive school health education is only part of the whole picture. The Act must be expanded to include this nation's urgent need for a comprehensive school health program that focuses on tobacco-free schools, school meals that meet federal dietary guidelines, physical fitness, and employee wellness programs, tied together with comprehensive school health education. In order to help our children stay healthy and live longer healthy lives and assure a high health status for the future populace of our country, a comprehensive school health program must be included as an essential component to health care reform.

American Heart Association   AMERICAN LUNG ASSOCIATION.   AMERICAN CANCER SOCIETY®

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Coalition on Smoking OR Health

Statement for the Record

on

The Health Security Act

Submitted to the

House Education and Labor Subcommittee on

Select Education and Civil Rights

Chairman Major Owens

Hearing on

January 26, 1994

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The Coalition on Smoking OR Health, comprised of the American Cancer Society, American Lung Association, and the American Heart Association, are pleased to see that comprehensive school health education is included in the Health Security Act. Comprehensive school health education is an important component of preventive health services and it is something we strongly endorse. We also commend the Clinton Administration for recognizing that tobacco use is a health risk behavior. States should create a comprehensive school health education program that targets the health risk that accounts for the majority of morbidity and mortality in this nation -- tobacco.

This nation's three largest voluntary health organizations united as the Coalition on Smoking OR Health in 1982 to educate public policy makers at the federal, state, and local levels about issues related to tobacco and disease prevention and health promotion. Tobacco use continues to be a major health problem in the United States. The Coalition believes that strong efforts should be made to discourage tobacco use in all segments of the population, including youth.

Tobacco use is the single largest preventable cause of death and disability in the United States, accounting for over 419,000 deaths each year at an estimated cost of $68 billion in direct health care costs and lost productivity. Every day over 3,000 children are lured into starting the tobacco habit before they reach the legal buying age. The 1990 report of the National Commission on Drug-Free Schools found that tobacco advertising clearly influences young people to take up the tobacco habit. It glamorizes and legitimizes tobacco usage and creates a false impression that tobacco products pose no significant health risk.

Many children begin the tobacco habit under the false assumption that they will be able to quit. However, due to the highly addictive nature of nicotine, many children begin this deadly habit and then are unable to stop. They become smokers for life, thereby decreasing their quality of life greatly increasing their risk for heart disease, lung cancer, other cancers, and emphysema.

Tobacco use has been recognized as a serious drug abuse problem by the World Health Organization and the U.S. Public Health Service. The National Institute of Drug Abuse has described cigarette smoking as the "most widespread example of drug dependence" in our nation. The 1988 Surgeon General's report, "The Health Consequences of Smoking:

Nicotine Addiction" documented that nicotine is a substance comparable in its physiological and psychological proprieties to other addictive substances, such as heroin and cocaine.

The Coalition on Smoking OR Health believes that tobacco-free schools are essential to preventing the initiation of tobacco use by children and to protecting nonsmokers from secondhand tobacco smoke. In order for a school health program to be comprehensive, it must include both education about the hazards of tobacco and a tobacco-free school environment. The Smoke-free Class of 2000, a program sponsored by the American Cancer Society, American Heart Association, and American Lung Association, provides an example of the tobacco component of a comprehensive school health program. The Healthy People 2000 Objectives call for establishing tobacco-free school environments as a means of reinforcing student knowledge of the health hazards of tobacco use and exposure to environmental tobacco smoke (ETS), as well as promoting a tobacco-free environment as the norm.

The Coalition believes that comprehensive school health education is an important component of preventive health services. An effective comprehensive school health education program must include programs that target tobacco use. In order to reinforce this standard comprehensive school health education can only be carried out in a tobacco-free environment.

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The American Association of University Women (AAUW) strongly supports the creation of a national health care system that ensures comprehensive and quality health care coverage for all Americans at an affordable cost. As an organization committed to improving the social, physical, and economic well-being of all individuals, AAUW believes that quality health care is a right, not a privilege.

Integral to achieving the goal of universal access to health care is availability of a wide range of service providers reaching as much of America's diverse population as possible. The creation of a health care continuum, from early childhood to old age, will require putting services where individuals and families can take advantage of them. AAUW believes that the schools must be key players in the provision of health services for children, and that school-based or school-linked clinics should be eligible for reimbursement by health care plans.

Services provided in a school-linked setting would improve both the health and educational performance of America's neediest children. It is obvious that students who suffer from depression or malnutrition, who become pregnant or have drug or alcohol problems cannot take full advantage of the educational programs available to them. And while coordination of services and health education would benefit all students, it has particular relevance to the lives and educational experiences of girls.

In 1992, the AAUW Educational Foundation released The AAUW Report: How Schools Shortchange Girls, highlighting a variety of issues that have an impact on the opportunities of girls to succeed in school and beyond. Among them were health needs currently given little attention and resources in most school systems. As this subcommittee reviews the President's and other alternative health care reform plans, AAUW urges that the needs of girls and young women, who represent 53 percent of the student population, be carefully considered and addressed.

Contraceptive Use and Sexually Transmitted Diseases (STDs)

The HIV infection rate for teenage girls is comparable to, and in some cases higher than, that for boys. While among adults, male AIDS cases are nine times more prevalent than female cases, the pattern of HIV infection among adolescents is very different. A 1989 study in the District of Columbia reports the HIV infection rate at 4.7 per 1000 for girls, almost three times the 1.7 rate for boys.

Comprehensive health education must be taught in all our nation's schools and must cover contraceptive use. STD counseling and contraceptives should be encouraged in school-based clinics to reverse this alarming trend.

Pregnancy

Research shows that nearly one-quarter of the school dropout rate is attributable to teen pregnancy. Nearly half of the girls who drop out do so because they are pregnant or have one or more children, making pregnancy a pressing educational issue, for young women and for the welfare of future generations. A mother's educational level is universally known to be one of the best indicators of her child's academic success. Children raised by mothers who never complete high school experience higher rates of academic failure and behavioral problems. Over half of all mothers now on welfare bore their first child as a teenager. Pregnancy prevention must be an integral part of health education programs and health services.

Health services for students who are already pregnant are also critical. Fully one-quarter of pregnant mothers receive no medical care of any sort during the crucial first trimester of pregnancy. About 20 percent of children with disabilities would not have that disability had their mother had one physical exam during this period (Phi Delta Kappan 9/91). The United States has a higher infant mortality rate than Japan, Canada, and most European countries, according to a recent report; the rate is particularly high for African American infants.

Every dollar spent on prenatal care saves $3.38 in the cost of caring for low birth weight babies. This is just one example of how putting health services in the schools can reach a needy segment of the population and make better use of scarce funding.

Eating Disorders

Food binging and chronic dieting are, sadly, a regular feature of the high school, junior high, and even upper elementary school landscape. A 1989 National Adolescent Health Survey of 10,000 public school students found that 61 percent of girls reported having dieted in the past year, compared with 28 percent of boys. Half of those who dieted had fasted as a means of weight loss. Girls are also more likely than boys to report vomiting to control their weight and to abuse over-the-counter appetite suppressants. Severe cases of bulimia and anorexia nervosa can cause death.

Diet counseling, nutrition and exercise information, and health education programs that consciously promote positive self-image can help combat forces in society that wreak havoc on girls' self-esteem.

Depression and Suicide

Shortchanging Girls, Shortchanging America, a study published by AAUW in 1991, found that girls' self-esteem drops dramatically as they move through adolescence. Other research shows that females have higher rates of depression than males, during both adolescence and adulthood. Severely depressed girls have been shown to have higher rates of substance abuse than similarly depressed boys. Significant gender differences were also found in school performance measures among the most depressed students: grade point averages were lower for girls, and 40 percent more girls failed a grade than boys. Adolescent girls are four to five times more likely than boys to attempt suicide (although boys, who choose more lethal methods, are more likely to be successful in their attempts).

RECOMMENDATIONS

Suggested Health Services: AAUW respects the importance of flexibility for grant recipients in deciding what services to offer and with whom to coordinate provision of services. However, we are also painfully aware that unless specified, the needs of females are often not met by school systems, in or out of the classroom. We urge greater specificity in listing the kinds of services to be provided by these initiatives. Services must include: pregnancy-related services, contraception, maternal and child health, lab and testing services, and counseling and information on eating disorders, nutrition, substance abuse, sexually transmitted diseases (including AIDS), and depression and suicide.

Comprehensive Health Education: AAUW advocates the promotion of comprehensive K-12 age-appropriate health education programs. Curricula should recognize and address the different needs of female and male students and actively seek to improve the self-image and self-esteem of students.

Referrals: School-based clinics should be given flexibility in the kinds of services they provide and be able to refer students to other easily-accessible health service providers where necessary.

Enabling Services: AAUW commends the Clinton Administration's inclusion of "enabling services," which increase the capacity of individuals to utilize the services in the comprehensive benefits package. Transportation is a key access issue for many young women and girls. We also urge that dependent care assistance, which was not listed in the Clinton bill, be specified in any health care reform plan.

Suggested Partners: AAUW urges inclusion of a list, in the section describing contents of the grant application, of suggested agencies and service providers that should be considered for partnership or advisory status. Certain segments of America's population seem continually at risk of being forgotten or excluded, unless attention is called to them early and often. A list of suggested partners should include juvenile justice workers, social workers, legal services offices, WIC and Welfare administrators, and service providers for migrant children, recent immigrants, and parents and children with limited English proficiency.

CONCLUSION

Throughout the health care reform process, AAUW will be working to ensure that women's health needs are recognized and met. AAUW believes that the coordination of health, social, and educational services in a school-based or school-linked setting, if sensitive to the needs of all students, is a critical "jumping-off point" for a lifelong system of comprehensive health services. We urge this subcommittee to help build successful coordinated service programs by ensuring that the needs of all students are recognized by those community leaders who will be planning and implementing this crucial aspect of health care reform.

Prepared statement of Julia Graham Lear, PhD, Director, Making the Grade: State and Local Partnerships to Establish School-Based Health Centers, and associate research professor, Department of Health Services, Management and Policy, The George Washington University.

Over the past 12 years, I have assisted the Robert Wood Johnson Foundation in administering several of its national grant programs which have addressed the health care needs of adolescents -- both in community-based locations and in school-based health centers. My experiences in working with the 40 grant recipients of the three programs that follow form the basis for my comments concerning school-based health care and health care reform.

- **From 1982 - 1986, the foundation supported 20 community-based programs for adolescents through its Program to Consolidate Health Services for High-Risk Young People.**
- **From 1987 - 1993, through The School-Based Adolescent Health Care Program the foundation supported the development of 24 school-based health centers through 18 grant awards to a variety of mainstream health care institutions whose school-based efforts were guided by local community and parent advisory groups.**
- **In 1993 the foundation launched a new initiative, Making the Grade, to assist state governments to reduce both organizational and financing barriers to school-based health care and provide stable funding. The program will also support the development of district-wide systems of school-based health centers in at least two communities in each state funded. This month the foundation awarded grants to 12 states to support a 15-month planning period. Grant recipients included Colorado, Connecticut, Delaware, Hawaii, Louisiana Maryland, New York, North Carolina, Oregon, Rhode Island, Tennessee, Vermont In 1995, the Foundation will award 10 four-year grants to support implementation of the program.**

The Robert Wood Johnson Foundation is the nation's largest health care philanthropy and was established as a national foundation in 1972. Over the past 15 years the Robert Wood Johnson Foundation has supported several national programs that have increased basic health care for children through school-based services.

Your commitment and that of many members of Congress and the Administration to health care reform is exciting and represents a milestone in

improving the ability of every American to secure health care when he or she is sick.

My purpose in coming before you today is to join others in emphasizing that for some Americans, particularly for some young people ages 10 - 17, access to health care will require more than a Health Security Card. That is why I was very pleased to see that the Clinton plan has made special efforts, through Title III of that of the Health Security Act to support the development of school-based health centers. These centers represent a recent and increasingly popular approach to expanding the availability of health care for school-age children and youth.

Adolescents have had well documented difficulties in securing access to care -- as an age group they have the highest rate of uninsured individuals; they have the fewest visits to the doctor; nearly half those visits last 10 minutes or less and if they do see a provider, it is unlikely that provider has been trained particularly in adolescent health care.

The limited contact between adolescents and the health care system should not be taken as evidence that adolescents do not need care. As reported by the Office of Technology Assessment, one of five adolescents suffer from at least one serious health problem, 5 - 10% have a chronic disease or disability such as asthma or heart disease or vision problems, and a much larger number (20 - 50%) are estimated to experience a range of less serious problems. In addition, one in four adolescents is believed to be at high risk for school failure, delinquency, early and unprotected sexual intercourse and substance abuse. Table 1 summarizes recent data from the Centers for Disease Control and Prevention that underscore the importance of these problems.

During the past twenty years, in communities across the country, parents, school officials, health providers and public agencies have begun to test the effectiveness of school-based health centers in providing care and responding to the particular needs of adolescents. What was once seen as controversial and as a vehicle for sexually-related services is now viewed in many areas as simply one of several ways in which communities try to address the obvious, yet unmet needs of adolescents.

School-based health centers, which began in just two cities -- St. Paul, Minnesota and Dallas, Texas -- just over 20 years ago, grew to 50 health centers in the 12 years that followed; and then grew from 50 to 500 in the decade beyond that.

A number of factors have contributed to the astonishing acceleration in the development of school-based health centers:

- The rate of child poverty increased during the 1980s, leading to governmental interest in offsetting the negative health and educational achievement consequences of poverty;

- Concern that too many young people were leaving school untrained to contribute to the workforce of the 21st century and an increased awareness that school success is linked to children being "ready-to-learn" spurred recommendations that health and other services be brought on campus;

- Adolescent problems, especially premature mortality due to automobile accidents, homicide and suicide; continued high rates of sexually transmitted disease and increased risk for HIV infection; sustained high rates of heavy alcohol use as well as health system barriers to addressing these problems encouraged efforts to find new ways of providing care to teens;

- Political opposition to health services delivery in school declined: first, because the advent of AIDS and fear of HIV infection has made parents and communities more willing to face the reality of adolescent sexual activity, and second, because increases in the number of salaried physicians, managed care arrangements and HMOs have made new ways or organizing health services more acceptable among health professionals.

- The emergence of mid-level practitioners -- nurse practitioners, physician assistants, and clinical social workers , their growing acceptability to patients, and their lower cost has made possible the development of cost-effective health care teams based in schools.

While not all school-based health centers are alike, there is consensus that the ideal center is multi-disciplinary, offers both physical and mental health services, emphasizes prevention as well as treatment, works in partnership with the school, and requires parental consent. (See Table 2)

From 1987 until 1993, 24 school-based health centers supported through the Johnson Foundation's The School-Based Adolescent Health Care Program reported on their experience in some detail. As indicated in Tables 3 - 13, data from those centers confirmed reports from earlier centers that school-based health centers could provide accessible, affordable health care to poor children. Key findings from the Program include the following:

1. Health Centers are popular with parents -- more than 70 percent of parents consent for their children to use the clinics. (Table 3)

2. Health centers are popular with students. 45% of the enrolled students use the clinics and the average visit rate is 4 visits per year per student. That the clinics are popular with students is demonstrated also by the high ratio of repeat visits to new visits. (Tables 4 and 4a)

3. The health centers have increased access to care for young people who do not have access to regular providers (Table 5), who have not seen a physician lately (Table 6), and who do not have health insurance (Table 7).

4. Health center use reflect the age (Table 8) and ethnicity (Table 9) of students enrolled in the schools .

5. Health services provided at the school are comprehensive and include a range of physical and mental health services (Table 10). Note that the leading services provided were care of acute illnesses and injuries (29%), mental health (18%), and physical examinations (15%). Reproductive health care accounted for 10% of the services.

6. The intensity of patient visits is suggested by both the length of patient visits and the numbers of prescriptions (Tables 11 and 12).

7. Most school-based health centers provide health education and health promotion services in school classrooms, at health fairs for school sport teams and for the parent and faculty organizations (Table 13).

The promising data that began to emerge from school-based health centers such as those funded by The Robert Wood Johnson Foundation fueled the remarkable expansion that occurred nationally -- despite the absence of direct federal support and despite sporadic opposition from some community-based as well as national groups that objected to addressing contraception in a school location or were concerned that health centers would come between parents and their children. In the end, support from parents who approved their children using the health centers and support from children and young people who sought care at the clinics eased concerns regarding their acceptability.

This past year our office surveyed all fifty state governments to learn whether they were involved in school-based health care initiatives. As of the Spring of 1993, 31 of the 50 states had initiated state-supported programs to develop school-based health centers. And this past summer, in response to The Robert Wood Johnson Foundation announcement of grants for the Making the Grade Program, 38 state governors plus the heads of the District of Columbia and Puerto Rican governments signed letters requesting that their jurisdictions be funded to develop new state programs in school-based health care.

This widespread interest in school-based health centers and the relative newness of these efforts makes us particularly interested in examining how heath care reform will take into account these very promising vehicles for providing care to adolescents. The following points summarize features that will make health care reform plans supportive of good school-based health centers:

- Universal access. With adolescents more likely to be uninsured than any other age group, they will benefit from all plans that provide them and their care to many young people without such coverage. At Far Rockaway High School health center, for example, 66% of the students had no medical reimbursement for care provided.

- Start-up support for school-based health centers. Currently, 500 schools have school-based health centers but there are 9,400 middle and senior high schools which are not currently served by health centers.

  A concern is where the money for the school-based health centers start-up will come from. Assuring support for initiating new centers would best be achieved by supporting this effort through the health care financing bill as terms of the Budget Enforcement Act of 1990.

- Recognition of the importance of local conditions and building on local resources. Nationally, schools and communities vary enormously in terms of students' needs, community resources, and parents' interests. Local factors need to be determinative.

- On-site care for physical health, mental health and substance abuse problems. As has been said many times, students don't travel well and they don't carry appointment books. If we want to get services to adolescents, we will need to take those services to them.

  One of the things that school-based health centers have demonstrated over the past decade is that the leading demand for service, after treatment for to provide mental health services on-site. Few communities have adequate existing mental health resources to treat adolescents and, the experience of reluctant to complete a mental health referral.

- Participation by a variety of community providers. School-based health centers participating in the School-based Adolescent Health Care Program have been successfully organized by hospitals, health departments, community health centers, and teaching hospitals. Other entities such as HMOs and group practices might also organize school-based health centers.

- Participation of school-based health centers in area health plans. The experience of school-based health centers in negotiating with managed care providers suggests that it will be important to mandate that all school-based health centers be brought under the essential community provider umbrella. Health centers have found that managed care organizations have been reluctant to contract for the care provided at the school sites.

Behavioral Risk Factors Among High School Students in the United States, 1991

Ever had sexual intercourse	54%
Had sexual intercourse with 4 or more partners	19%
Smoked cigarettes past 30 days	28%
Used marijuana past 30 days	15%
Had 5 or more drinks on one occasion past 30 days	31%
Were in physical fight past year	42%
Carried a weapon past 30 days	26%
Did not always wear safety belts	72%
Had 5 or more servings of fruits & vegetables yesterday	13%
Not enrolled in physical education	51%
Attempted suicide past year	7%

TABLE 2

School-Based Health Center Model

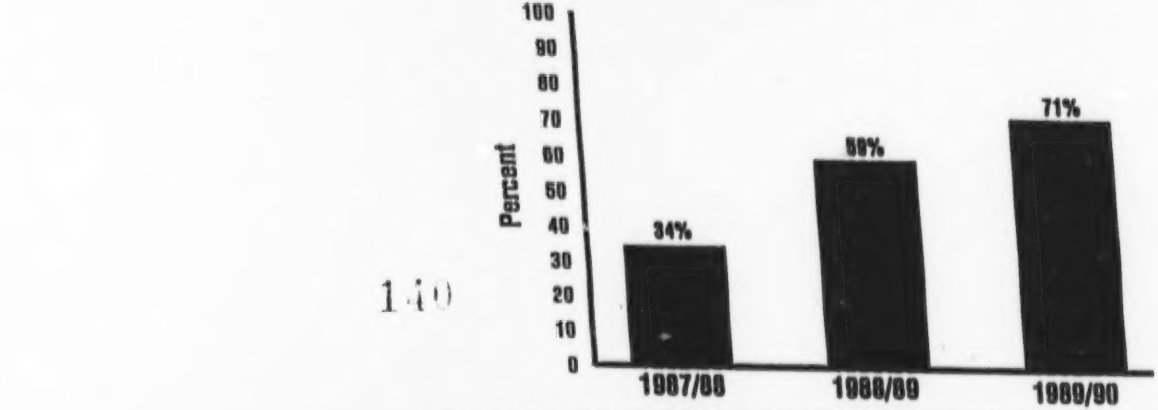
- Located in school or on school campus
- Parental consent policy required
- Overseen by advisory board composed of community reps, youth, parents, other appropriate individuals or agencies
- Cooperative linkages with school nurses, teachers, coaches, school administration
- Staffed by multidisciplinary team of nurse practitioners, clinical social workers, physicians and other health professionals
- Provides a comprehensive range of services to meet the serious health problems of young people in the community as well as provide general medical care

Source: School-based Adolescent Health Care Program, The George

TABLE 3

SCHOOL-BASED ADOLESCENT HEALTH CARE PROGRAM

PERCENTAGES OF STUDENTS WHOSE PARENTS CONSENTED TO CARE



Source: School-based Adolescent Health Care Program, The George Washington University, Washington, D.C. 1993.

TABLE 4. SCHOOL ENROLLMENT AND CLINIC UTILIZATION

	School Population	Clinic Users	Total Visits	Visit Rate
1989/1990[a]	34,106	15,748 (46%)	59,069	3.7
1990/1991[a]	33,672	14,453 (44%)	61,454	4.1
1991/1992[b]	37,189	16,650 (45%)	66,481	4.0

[a] 23 school-based health centers
[b] 24 school-based health centers

Source: School-based Adolescent Health Care Program, The George Washington University, Washington, D.C., 1993

TABLE 4a. **PATIENT VISIT DATA**

	1988/ 1989	1989/ 1990	1990/ 1991	1991/ 1992
Total Visits	49,337	59,069	61,454	66,481
Repeat visits	81%	84%	86%	84%
New visits	19%	16%	14%	16%

Source: School-based Adolescent Health Care Program, The George Washington University, Washington, D.C. 1993.

TABLE 5

ACCESS TO HEALTH CARE FOR NEW PATIENTS

Previous routine source of care	1988/ 1989	1989/ 1990	1990/ 1991	1991/ 1992
Physician/clinic	63%	72%	52%	54%
Emergency room	8%	8%	7%	9%
No regular source of care	29%	21%	41%	36%

Source: School-based Adolescent Health Care Program, The George Washington University, Washington, D.C. 1993.

TABLE 6

ACCESS TO HEALTH CARE FOR NEW PATIENTS

Most recent medical care	1988/ 1989	1989/ 1990	1990/ 1991	1991/ 1992
Within 1 year	59%	58%	59%	44%
1-2 years	22%	21%	21%	27%
2+ years	19%	21%	20%	29%

Source: School-based Adolescent Health Care Program, The George Washington University, Washington, D.C., 1993

TABLE 7

ACCESS TO HEALTH CARE FOR NEW PATIENTS

Insured status	1988/ 1989	1989/ 1990	1990/ 1991	1991/ 1992
Medicaid	24%	18%	20%	30%
Private insurance	27%	25%	19%	23%
Self Pay	49%	58%	62%	48%

Source: School-based Adolescent Health Care Program, The George Washington University, Washington, D.C. 1993.

TABLE 8

PATIENT VISITS BY AGE

	1988/ 1989	1989/ 1990	1990/ 1991	1991/ 1992
13 and under	8%	6%	6%	9%
14-15	33%	29%	31%	29%
16-17	43%	49%	49%	44%
18-19	17%	12%	13%	14%
20+	<1%	1%	1%	1%

Source: School-based Adolescent Health Care Program, The George Washington University, Washington D.C. 1993.

TABLE 9

PATIENT VISITS BY RACE/ETHNICITY

	1988/ 1989	1989/ 1990	1990/ 1991	1991/ 1992
Asian	2%	1%	3%	2%
African American	56%	57%	51%	55%
Hispanic	21%	19%	26%	25%
Non-Hispanic white	19%	20%	18%	16%
Other	3%	3%	3%	2%

Source: School-based Adolescent Health Care Program, The George Washington University, Washington, D.C. 1993.

TABLE 10

HEALTH SERVICES PROVIDED*

	1990/ 1991	1991/ 1992
Acute illness	32%	29%
Chronic health problems	6%	6%
Acne, other skin problems	4%	4%
Physical exams	13%	15%
Mental health	14%	18%
Reproductive health, STDs, family planning	9%	10%
Prenatal care	2%	1%
Nutrition, eating disorders	4%	3%
Drug/alcohol abuse	2%	2%
Other, incl. immunization, vision, hearing	14%	12%

*Primary service/diagnosis only
Source: School-based Adolescent Health Care Program, The George Washington University, Washington, D.C. 1993.

TABLE 12

PRESCRIPTIONS WRITTEN OR DISPENSED

1988/ 1989	1989/ 1990	1990/ 1991	1991/ 1992
6,939	7,158	10,575	10,500*

*One project not reporting.

Source: School-based Adolescent Health Care Program, The George Washington University, Washington, D.C. 1993.

TABLE 13

PARTICIPATION IN EXTRAMURAL ACTIVITIES BY ACTIVITY TYPE* - 1990

	Participating projects (n)
Classroom health education	16
School-wide health fairs	9
School-wide immunization programs	8
PTA/other parent education	7
Non-clinic sports/other physicals	6
School-wide crisis intervention teams	5
Teacher education	5
Drop-out prevention	5

*Activities reported by 18 program grantees.

Source: School-based Adolescent Health Care Program, The George Washington University, Washington, D.C. 1993

STATEMENT SUBMITTED BY
MARGARET A. HAMBURG, M.D.
to the public record of the
Subcommittee on Select Education and Civil Rights

The New York City Department of Health is pleased to participate in these hearings on school health and federal health care reform. New York City is a strong supporter of school-based health services because we believe they are a vital resource for meeting the health needs of underserved young people, especially adolescents. We are pleased that the President and First Lady have recognized the importance of both school-based health education and health care services and have included them in their proposal for national health care reform. The direction and expanded funding for school health education and services proposed in the Health Security Act are significant and if implemented, will have a major impact on some of the most intransigent health care problems affecting children and youth in low income communities.

New York City has been a pioneer in providing school health services as well as in the school-based clinic movement. The Department's own school health service began in 1897 and when fully developed in the 1940s was a model for many communities throughout the country. The foundation of the program was its emphasis on concentrating on comprehensive school health services for children most in need of care, and not merely on doing routine annual health examinations.

Despite funding cuts over the years, the Department has been able to maintain a public health model school health program for the city's 1142 schools and its 1.2 million students (Kindergarten through grade 12). We also fund the provision of comprehensive primary health care for students at five adolescent school-based clinics located throughout New York City. A sixth adolescent school-based clinic provides only mental health services for its students. The Department is now embarked on an additional five year $25 million rebuilding of the program. Major new directions in the five year plan are the establishment of a daily health presence in each school, the establishment of dedicated teams for each school, and expanded activity in individual schools that are recognized to be at highest health risk.

This new direction clearly recognizes that many students in New York City do not have a medical home, and that the role of the school health program should be to link them with appropriate health care resources that can provide comprehensive care. In the expansion program, the Department of Health would have liked to expand the number of school-based clinics in New York City, but our mandated role as the provider of last resort for all NYC school children, combined with the lack of sufficient funding, prevented us from doing so.

The work of our five school-based clinics, and our advocacy in support of the 140 other school-based clinics in New York City have convinced us that school-based clinics are the best way to provide primary care services to children and youth living in low income communities. Primary care shortages in New York City's poor communities are so great that even if national health reform provides insurance coverage, the lack of providers will limit the ability of children and youth to obtain health services. School-based services are an especially important resource for adolescents who are too old to be escorted to a doctor by a parent and too young to establish and maintain an adequate health care routine on their own. School based health centers are an excellent model because they are accessible and comprehensive and much less expensive to capitalize and operate than community-based primary care sites.

Our experience in school health and with school-based clinics has taught us the following lessons:

1. School-based health services must be comprehensive, must include complete medical services provided by a physician extender, e.g. nurse practitioner, physician assistance, etc., and operate within a protocol supervised by a part-time physician. Mental health and social support services should also be provided. The Health Security Act proposes that school-based clinics will automatically be designated as essential community providers and payment for covered services will eventually be obtained from health plans. Payments must be adequate to cover a comprehensive set of services including mental health and dental services.

2. School-based clinics established prior to the implementation of health care reform must be given the same protection; i.e. allowed to become essential community providers and provider sites for managed care plans. This is necessary to ensure the clinics' survival in a reformed health care system.

3. In addition to an adequate capitation rate from health plans, an adequate and stable funding stream to support school based clinics is essential. The funding from the Health Security Act will be essential because some of the students serviced in these clinics will be new immigrants and thus not eligible for a Health Security Card. School-based clinics are the only source of health services for many new immigrants and grant funding must be sufficient to pay for the services they need.

4. Partnerships among public health and education agencies and community-based health providers are critical to the development of the clinic in a school and to the ongoing successful operation of the clinics. The Health Security Act recognizes the importance of these partnerships and we applaud this.

The New York City Department of Health, as a member of the New York City Coalition for School Based Primary Care, is working with both our school-based clinics and others, and is actively involved with all these issues. We support the measures to improve school health because we believe this is the best way to assure that low income children and youth are able to obtain high quality comprehensive and cost effective health services.

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ISBN 0-16-044570-1
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